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Department of Health

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Category 1

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

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

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GENERAL EXPLANATORY NOTES

GENERAL EXPLANATORY NOTES

GN.1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

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

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

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

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

a. Free treatment for public patients in public hospitals.
b. The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are
    i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
    ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or Aboriginal and Torres Strait Islander health practitioner;
    iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
    iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

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

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

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

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

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

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

The Department of Human Services (DHS) has developed a Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service. There is also a Health Practitioner Guideline for substantiating that a specific treatment was performed. These guidelines are located on the DHS website.

GN.2.4 Provider eligibility for Medicare

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

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

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

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

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

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

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

Non-medical practitioners

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

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

(b) registered with the Department of Human Services to provide these services.

GN.2.5 Provider Numbers

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

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

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

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

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

GN.2.6 Locum tenens

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

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

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

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

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

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

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

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

GN.2.8 Contact details for the Department of Human Services

Changes to Provider Contact Details

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

Medicare

GPO Box 9822

in your capital city

or

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

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

MBS Interpretations

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

or by phone on 132 150

GN.3.9 Patient eligibility for Medicare

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

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

GN.3.10 Medicare cards

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

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

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

GN.3.11 Visitors to Australia and temporary residents

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

GN.3.12 Reciprocal Health Care Agreements

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

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

Exceptions:

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

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

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

GN.4.13 General Practice

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

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

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

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

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

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

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

Vocational recognition of general practitioners

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

(a) certification by the RACGP that the practitioner

· is a Fellow of the RACGP; and

· practice is, or will be within 28 days, predominantly in general practice; and

· has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner

· is a Fellow of the RACGP; and

· practice is, or will be within 28, predominantly in general practice; and

· has met minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.

(c) certification by ACRRM that the practitioner

· is a Fellow of ACRRM; and

· has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the

practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

QI&CPD Program Administrator, RACGP

Tel: 1800 472 247 Email at: qicpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Email at gprec@health.gov.au

Executive Assistant, ACRRM:

Tel: (07) 3105 8200 Email at acrrm@acrrm.org.au

How to apply for vocational recognition

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

The Secretariat

The General Practice Recognition Eligibility Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprec@health.gov.au

The Secretariat

The General Practice Recognition Appeal Committee

National Registration and Accreditation Scheme Policy Section

MDP 152

Department of Health

GPO Box 9848

CANBERRA ACT 2601

email address: gprac@health.gov.au

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

Continued vocational recognition is dependent upon:

(a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and

(b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

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

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

Removal of vocational recognition status

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

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

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

GN.5.14 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

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

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

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

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

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

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

Further information about applying for recognition is available at the Department of Human Services' Medicare website.

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

GN.5.15 Emergency Medicine

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

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

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

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

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

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

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

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

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

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services.

What is a Referral?

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

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

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

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

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

The exceptions to the requirements in paragraph above are that

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

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

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

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

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

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

(i) a recognised specialist:

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

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

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

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

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

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

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

Billing

Routine Referrals

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

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

- date of referral; and

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

Special Circumstances

(i) Lost, stolen or destroyed referrals.

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

(ii) Emergencies

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

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

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

Definition of a Single Course of Treatment

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

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

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

However, where the referring practitioner:-

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

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

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

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

Retention of Referral Letters

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

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

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

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

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

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

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

Self Referral

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

GN.7.17 Billing procedures

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

Bulk billing

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

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

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

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

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

GN.8.18 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

the characteristics of the patients.

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

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

Additional Information

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

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

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

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

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

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

GN.8.19 Medicare Participation Review Committee

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

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

(b) has breached an Approved Pathology Practitioner undertaking;

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

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

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

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

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

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

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

GN.8.21 Comprehensive Management Framework for the MBS

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

GN.8.22 Medical Services Advisory Committee

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

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

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

GN.8.23 Pathology Services Table Committee

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

GN.9.25 Penalties and Liabilities

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

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

GN.10.26 Schedule fees and Medicare benefits

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

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

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

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

There are presently three levels of Medicare benefit payable:

a. 75% of the Schedule fee:
    i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'admitted' or 'in patient');
    ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.
b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner.
c. 85% of the Schedule fee, or the Schedule fee less $83.40 (indexed annually in November), whichever is the greater, for all other professional services.

Public hospital services are to be provided free of charge to eligible persons who choose to be treated as public patients in accordance with the National Healthcare Agreement.

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

The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.

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

GN.10.27 Medicare safety nets

The Medicare Safety Nets provide families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net.

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2018 is $461.30. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

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

In 2018, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB (A) is $668.10. The threshold for all other singles and families in 2018 is $2,093.30.

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

Individuals are automatically registered with the Department of Human Services for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed online at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

EMSN Benefit Caps:

The EMSN benefit cap is the maximum EMSN benefit payable for that item and is paid in addition to the standard Medicare rebate. Where there is an EMSN benefit cap in place for the item, the amount of the EMSN cap is displayed in the item descriptor.

Once the EMSN threshold is reached, each time the item is claimed the patient is eligible to receive up to the EMSN benefit cap. As with the safety nets, the EMSN benefit cap only applies to out-of-hospital services.

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

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

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

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

GN.11.28 Services not listed in the MBS

Benefits are not generally payable for services not listed in the MBS. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic

keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);

(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;

(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14245);

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

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

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

(g) All Group T6 (Anaesthetics) items;

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

(i) All Group T8 (Operations) items;

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

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

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

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

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

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

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

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

Supervision from outside of Australia is not acceptable.

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

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

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

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

GN.12.32 Medicare benefits and vaccinations

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

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

(a) telephone consultations;

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

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

(d) non-therapeutic cosmetic surgery;

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

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

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

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

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

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

Unless the Minister otherwise directs

Medicare benefits are not payable where:

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

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

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

(d) the service is a health screening service.

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

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

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

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

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

(d) the removal of tattoos;

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

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

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

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

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

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

(b) gamma knife surgery;

(c) intradiscal electro thermal arthroplasty;

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

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

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

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

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

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

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

(k) specific mass measurement of bone alkaline phosphatase;

(l) transmyocardial laser revascularisation;

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

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

(o) vertebroplasty

Health Screening Services

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

(a) multiphasic health screening;

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

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

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

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

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

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

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

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

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

(d) a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or

collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

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

(f) a medical examination being a requisite for Social Security benefits or allowances;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. a de facto spouse of that person.

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

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

b. a person who:

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

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

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

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

GN.14.34 Principles of interpretation of the MBS

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

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

GN.14.35 Services attracting benefits on an attendance basis

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

GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

GN.14.37 Aggregate items

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

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

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

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

CATEGORY 1: PROFESSIONAL ATTENDANCES

SUMMARY OF CHANGES FROM 01/11/2018

The 01/11/2018 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number:

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

New Items

371 372 894 896 898 2121 2150 2196 2729 2731

Fee Amended

181 183 187 188 191 202 206 212

New MBS Items for GPs and Medical Practitioners Delivering Focussed Psychological Strategies by Telehealth

From 1 November 2018, appropriately trained general practitioners and non-specialist medical practitioners will be able to provide focussed psychological strategies via telehealth under Medicare in rural and remote areas (Modified Monash areas 4 to 7).

The purpose of this is to support the mental health, well being and resilience of farming communities, and to support people in rural and remote communities who choose to complete their treatment using this channel.

MBS Mental Health and Well-Being Telehealth Support Items for Patients in Drought-Affected Communities

Six new Medicare Benefits Schedule (MBS) items have been introduced to enable GPs and non-specialist medical practitioners to provide general mental health and well-being support services by video conference to patients in drought-affected areas.

MBS items 2121, 2150 and 2196 (for GPs) and MBS items 894, 896 and 898 (for non-specialist medical practitioners) may be used to provide telehealth services by doctors working in areas belonging to declared councils under the DCP, or in Modified Monash (MM) areas 3 to 7, where there is an existing relationship between the doctor and the patient.

The Mental Health and Well-Being Telehealth Support items replicate the requirements and MBS rebates for the current Level B to D general attendance items for services in consulting rooms that are available to GPs and non-specialist medical practitioners. The items also align with the existing MBS arrangements for video conference services, including the requirement that, at the time of the attendance, the patient must be at least 15 kilometres by road from the doctor providing the service.

PROFESSIONAL ATTENDANCES NOTES

AN.0.1 Personal Attendance by Practitioner

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

AN.0.2 Benefits For Services

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

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

AN.0.3 Professional Attendances

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

AN.0.4 Provider Numbers

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

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

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

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

Locum Tenens

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

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

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

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

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

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

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

AN.0.5 Services not Attracting Medicare Benefits

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

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

AN.0.6 Patient Eligibility

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

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

Medicare Cards

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

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

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

Visitors to Australia and temporary residents

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

Reciprocal Health Care Agreements

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

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

Exceptions:

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

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

The RHCAs do not cover treatment as a private patient in a public or private hospital. People visiting Australia for the purpose of receiving treatment are not covered. Visitors from New Zealand and the Republic of Ireland are NOT entitled to optometric treatment under a RHCA.

AN.0.7 Multiple Attendances on the Same Day

Payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner provided the subsequent attendances are not a continuation of the initial or earlier attendances.

However, there should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

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

In some circumstances a subsequent attendance on the same day does in fact constitute a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then an hour or so later eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. Further examples are the case of skin sensitivity testing, and the situation where a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

AN.0.8 Benefits For Optometrists

What services are covered?

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

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

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

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

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

Benefits may only be claimed when:

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

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

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

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

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

Where Medicare benefits are not payable

Medicare benefits may not be claimed for attendances for:

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

(b) filling of prescriptions written by other practitioners.

Benefits are not payable for optometric services associated with:

(a) cosmetic surgery;

(b) refractive surgery;

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

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

(e) entrance to schools or other educational facilities;

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

(g) vision screening.

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

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

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

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

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

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

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

(i) the employer arranges or requests the consultation

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

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

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

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

workplace.

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

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

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

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

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

(b) a de facto spouse of that person.

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

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

(b) a person who:

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

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

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

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

AN.0.9 Attendances by General Practitioners (Items 3 to 51, 193, 195, 197, 199, 585, 594, 599, 2497-2559 and 5000-5067)

Attendances by General Practitioners (Items 3 to 51, 193, 195, 197, 199, 585, 594, 599, 2497-2559 and 5000-5067)

Items 3 to 51 and 193, 195, 197, 199, 585, 594, 599, 2497-2559 and 5000-5067 relate to attendances rendered by medical practitioners who are:

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

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

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

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

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

To assist general practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL A

A Level A item will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

LEVEL B

A Level B item will be used for a consultation lasting less than 20 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

LEVEL C

A Level C item will be used for a consultation lasting at least 20 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

LEVEL D

A Level D item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more health related issues. The medical practitioner may undertake all or some of the tasks set out in the item descriptor as clinically relevant, and this should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Creating and Updating a Personally Controlled Electronic Health Record (PCEHR)

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

· Reviewing a patient's clinical history, in the patient's file and/or the PCEHR, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or

· Preparing an Event Summary for the episode of care.

Preparing or updating a Shared Health Summary and preparing an Event Summary are clinically relevant activities. When either of these activities are undertaken with any form of patient history taking and/or the other clinically relevant activities that can form part of a consultation, the item that can be billed is the one with the time period that matches the total consultation time.

MBS rebates are not available for creating or updating a Shared Health Summary as a stand alone service.

Counselling or Advice to Patients or Relatives

For items 23 to 51 and 5020 to 5067 'implementation of a management plan' includes counselling services.

Items 3 to 51 and 5000 to 5067 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance

Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see the General Explanatory Notes for further information on the interpretation of the Schedule).

The Department of Human Services (DHS) has developed an Health Practitioner Guideline for responding to a request to substantiate that a patient attended a service which is located on the DHS website.

AN.0.10 Schedule Fees and Medicare Benefits

Medicare benefits are based on fees determined for each optometrical service. The services provided by participating optometrists which attract benefits are set out in the *Health Insurance (General Medical Services Table) Regulations* (as amended).

If the fee is greater than the Medicare benefit, optometrists participating in the scheme are to inform the patient of the Medicare benefit payable for the item, at the time of the consultation and that the additional fee will not attract benefits.

Medicare benefits are payable at 85% of the Schedule fee for services rendered.

Medicare Safety Nets

The Medicare safety net provides families and singles with an additional rebate for out-of-hospital Medicare services, once annual thresholds are reached. There are two safety nets: the original Medicare safety net and the extended Medicare safety net (EMSN).

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee.

Under the EMSN, once an annual threshold in out-of-pocket costs for out-of-hospital Medicare services is reached, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, where the item has an EMSN benefit cap, there is a maximum limit on the EMSN benefit that will be paid for that item. Further explanation about EMSN benefit caps is provided at www.mbsonline.gov.au.

The thresholds for the Medicare safety nets are indexed on 1 January each year.

Individuals are automatically registered with the Department of Human Services for the safety nets, however couples and families are required to register in order to be recognised as a family for the purposes of the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from the Department of Human Services offices, or completed at www.humanservices.gov.au. If you have already registered it is important to ensure your details are up to date.

Further information on the Medicare safety nets is available at http://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net.

Limiting rule for patient claims

Where a fee charged for a service is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

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

Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (e.g. 10.30 am and 3.15 pm) in order to assist in the payment of benefits. Times do not need to be specified where a perimetry item is performed in association with a consultation item.

In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Release of prescription

Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by any person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.

Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient, other than attendances provided by vocationally or non-vocationally trained general practitioners. The aftercare period includes all post-operative treatment, when provided by a medical specialist, consultant physician or optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances unrelated to the operation provided by a vocationally or non-vocationally registered general practitioner in the aftercare period can also attract Medicare benefits. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.

The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.

Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and the receipt issued to the patient should clearly indicate the fee is non-rebatable.

Single Course of Attention

A reference to a single course of attention means:

(a) In the case of items 10905 to 10918, and old item 10900 - a course of attention by one or more optometrists in relation to a specific episode of optometric care.

(b) In relation to items 10921 to 10930 - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses. This includes those after-care visits necessary to ensure the satisfactory performance of the lenses.

Referred comprehensive initial consultations (item 10905) - Read in conjunction with 08 Referrals

For the purposes of item 10905, the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.

Benefits will be paid at the level of item 10905 providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist. Referrals from medical practitioners do not attract benefits under item 10905.

The optometrist claiming the item 10905 service is obliged to retain the written referral for a period of twenty-four months.

Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation, within 36 months for a patient who is less than 65 years of age and once every 12 months for a patient who is at least 65 years of age, of a previous comprehensive consultation (item 10907)

A patient can receive a comprehensive initial consultation by another optometrist within 36 months if the patient is less than 65 years of age, and once every 12 months if the patient is at least 65 years of age, if the patient has attended another optometrist for an attendance to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Comprehensive initial consultations (items 10910 and 10911)

There are two new MBS items for comprehensive initial consultation that have been introduced. Item 10910 has been introduced for a professional attendance of more than 15 minutes for a patient who is less than 65 years of age. This item is payable once only within a 36 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

Item 10911 has been introduced for a professional attendance of more than 15 minutes for a patient who is at least 65 years of age. This item is payable once only within a 12 month period, and if the patient has not received a service in this timeframe to which item 10905, 10907, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or old item 10900 applied.

However, a benefit is payable under item 10912, 10913, 10914 or 10915 where the patient has an ocular condition which necessitates a further course of attention being started within 36 months for a patient who is less than 65 years of age (item 10910) and within 12 months for a patient who is at least 65 years of age (item 10911) of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items.

Where an attendance would have been covered by item 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915 but is of 15 minutes duration or less, item 10916 (Short consultation) applies.

Significant change in visual function requiring comprehensive re-evaluation (item 10912)

Significant changes in visual function which justify the charging of item 10912 could include documented changes of:

· vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)

· visual fields or previously undetected field loss

· binocular vision

· contrast sensitivity or previously undetected contrast sensitivity loss.

New signs or symptoms requiring comprehensive re-evaluation (item 10913)

When charging item 10913 the optometrist should document the new signs or symptoms suffered by the patient on the patient's record card.

Progressive disorder requiring comprehensive re-evaluation (item 10914)

When charging item 10914, the optometrist should document the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy) cataract, corneal dystrophies, glaucoma etc.

Examination of the eyes of a patient with diabetes mellitus (item 10915)

Where an examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus is being conducted, where possible this item should be billed rather than item 10914 to assist in identifying whether such patients are receiving appropriate eye care.

Second or subsequent consultations (item 10918)

Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by item 10918.

Contact lens consultations (items 10921 to 10930)

In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in items 10921 to 10929.

For claims under items 10921,10922,10923,10925 and 10930, eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.

Medicare benefits are not payable for item 10929 in circumstances where a patient wants contact lenses for:

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

(b) sporting purposes;

(c) work purposes; or

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

All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under items 10921 to 10930, as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. In some cases, where the patient decides not to proceed with contact lenses, no Medicare fee is payable because the patient has not taken delivery of the lenses. In such instances, the patient may be charged a non-rebatable (private) fee for a 'part' service. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the relevant item in the range 10921 to 10930. The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses.

Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not items 10921 to 10930).

For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".

Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (e.g. balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.

When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.

Benefit under items 10921 to 10929 is payable once only in any period of 36 consecutive months except where circumstances are met under item 10930 within a 36 month period.

Domiciliary visits (items 10931 - 10933)

Where patients are unable to travel to an optometrist's practice for treatment, and where the request for treatment is initiated by the patient, a domiciliary visit may be conducted, which involves the optometrist travelling to the patient's place of residence, and transporting the necessary equipment. Where possible, it is preferable that the patient travel to the practice so that the full range of equipment is available for the examination of the patient.

Benefits are payable under items 10931 - 10933 to provide some financial assistance in the form of a loading to the optometrist, in recompense for travel costs and packing and unpacking of equipment. The loading is in addition to the consultation item. For the purposes of the loading, acceptable places of residence for domiciliary visits are:

- the patient's home;

- a residential aged care facility as defined by the *Aged Care Act 1997;* or

- an institution which means a place (other than a residential aged care facility or hospital) at which residential accommodation and/or day care is made available to any of the following categories: disadvantaged children, juvenile offenders, aged persons, chronically ill psychiatric patients, homeless persons, unemployed persons, persons suffering from alcoholism, persons addicted to drugs, or physically or intellectually disabled persons.

Visits to a hospital at the patient's request are not covered by the loading and instead, an extra fee in addition to the Schedule fee can be charged, providing the service is not bulk-billed. Medicare benefits are not payable in respect of the private charge.

Items 10931 - 10933 may be used whether or not the optometrist chooses to bulk-bill but it is important that if the consultation is bulk-billed the loading is also, and no private charge can then be levied. If the consultation is not bulk-billed, the loading should also not be bulk-billed and a private charge may be levied. The usual requirement that the patient must have requested the domiciliary visit applies.

The choice of appropriate item in the range 10931 - 10933 depends on how many patients are seen at the one location. Benefits are payable under item 10931 where the optometrist travels to see one patient at a single location. Item 10931 can be billed in addition to the consultation item. If the optometrist goes on to see another single patient **at a different location**, that patient can also be billed an item 10931 plus the consultation. However, if two patients are visited at a single location on the same occasion, each of the two patients should be billed item 10932 as well as the consultation item applying to each patient. Similarly, if three patients are visited at a single location on the same

occasion, each of the three patients should be billed item 10933 as well as the consultation item applying to each patient.

Where more than three patients are seen at the same location, additional benefits for domiciliary visits are not payable for the fourth, fifth etc patients. On such occasions, the first three patients should be billed item 10933 as well as the appropriate consultation item, and all subsequent patients may only be billed the appropriate consultation item. Where multiple patients are seen at one location on one occasion, there is no provision for patients to be 'grouped' into twos and threes for billing purposes.

Where a private charge is levied for a domiciliary visit, bulk-billing is precluded. Medicare benefits are not payable in respect of the private charge and the patient should be informed of this. Private charges should be shown separately on accounts issued by optometrists and must not be included in the fees for the service. Domiciliary visit loading items cannot be claimed in conjunction with brief initial consultation item 10916, or with computerised perimetry items 10940 or 10941.

Computerised Perimetry Services (items 10940 and 10941)

Benefit under items 10940 and 10941 is payable where full quantitative computerised perimetry (automated absolute static threshold but not including multifocal multichannel objective perimetry) has been performed by an optometrist on both eyes (item 10940) or one eye (item 10941) where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain. Item 10940 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 10941 for unilateral procedures should be claimed, where appropriate.

These items can be billed either in association with comprehensive consultation items 10905, 10907, 10910, 10911, 10912, 10913, 10914, or 10915, or independently, but they cannot be billed with items 10916, 10918, 10931, 10932 or 10933. An assessment and report is required and, where referral to an ophthalmologist for further treatment is required, the printed results of the perimetry should be provided to the ophthalmologist to discourage repetition of perimetry unless clinically necessary. If Medicare benefits are to be claimed, a maximum of two perimetry services in any twelve month period may be provided.

Low Vision Assessment (item 10942)

A benefit is payable under item 10942 where one or more of the tests outlined in the item description are carried out on a patient who has already been established during a comprehensive consultation as having low vision, as specifically defined in the item. This item is not intended for patients expected to undergo cataract surgery in the near future who may temporarily meet the criteria for having low vision.

Item 10942 may be claimed on the same day as either a comprehensive initial consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional low vision testing has been carried out on an eligible patient. Item 10942 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Children's vision assessment (item 10943)

Children aged 0 to 2 years, and 15 years and over, are not eligible for item 10943 and may be treated under appropriate attendance items.

A benefit is payable under item 10943 where one or more of the assessment and testing procedures outlined in the item description are carried out on a patient aged 3 - 14 years inclusive, and where a finding of significant binocular or accommodative dysfunction is the outcome of the consultation and assessment/testing. The conditions to be assessed under this item are primarily amblyopia and strabismus, but dysfunctions relating to vergences are also covered, providing well established and evidence based optometry practice is observed.

A benefit is not payable under item 10943 for the assessment of learning difficulties or learning disabilities.

Item 10943 may be claimed on the same day as either a comprehensive consultation (items 10905 - 10915) or a subsequent consultation (item 10918), but only where the additional assessment/testing has been carried out on an

eligible child. Item 10943 is not intended to be claimed with a brief initial consultation (item 10916), or with any of the contact lens items (items 10921-10930).

Removal of an embedded corneal foreign body (item 10944)

Item 10944 has been introduced for the complete removal of an embedded corneal foreign body that is sub-epithelial or intra-epithelial and the removal of rust rings from the cornea.

The removal of an embedded foreign body should be performed using a hypodermic needle, foreign body gouge or similar surgical instrument, with magnification provided by a slit lamp biomicroscope, loupe or similar device.

The optometrist should document the nature of the embedded foreign body (sub-epithelial or intra-epithelial), method of removal and the magnification. Similarly, with rust ring removal, the optometrist should document the method of removal and the magnification.

Where complexity of the procedure is beyond the skill of the optometrist, or if other complications are present (e.g. globe perforation, penetration >25%, or patient unable to hold still due to pathological anxiety, nystagmus, or tremor etc, without some form of systemic medication), the patient should be referred to an ophthalmologist.

This item cannot be billed on the same occasion as items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body or rust ring has not been completely removed, benefits are only payable under item 10916.

AN.0.11 Professional Attendances at an Institution (Items 4, 24, 37, 47, 58, 59, 60, 65, 5003, 5023, 5043, 5063, 5220, 5223, 5227 and 5228)

For the purposes of these items an "institution" means a place (not being a hospital or residential aged care facility) at which residential accommodation or day care or both such accommodation and such care is made available to:-

(a) disadvantaged children;

(b) juvenile offenders;

(c) aged persons;

(d) chronically ill psychiatric patients;

(e) homeless persons;

(f) unemployed persons;

(g) persons suffering from alcoholism;

(h) persons addicted to drugs; or

(i) physically or intellectually disabled persons.

AN.0.12 Billing Procedures

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

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

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

(c) the optometrist may bill Medicare instead of the patient for the consultation. This is known as bulk billing. If an optometrist direct-bills, they undertake to accept the relevant Medicare benefit as full payment for the

consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Claiming of benefits

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

Paid accounts

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

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

Department of Human Services

GPO Box 9822

In the claimant's capital city

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

Telephone Claiming

Department of Human Services

GPO Box 9847

In the claimant's capital city

Practitioners seeking information regarding registration to allow EFT payments and other E-Business transactions, can do so by viewing the Health Professionals section at the Department of Human Services at www.humanservices.gov.au.

Unpaid accounts

Where the patient has not paid the account in full, the unpaid account may be presented to the Department of Human Services with a completed Medicare claim form. In this case the Department of Human Services will forward to the claimant a benefit cheque made payable to the optometrist.

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

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

Itemised accounts

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

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

(a) patient's name;

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

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

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

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

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

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

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

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

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

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

Duplicate accounts

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

Assignment of benefit (bulk billed) arrangements

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

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

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

· the assignment of benefit forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;

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

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

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

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

- the notation "Patient unable to sign" and
- in the section headed 'Practitioner's Use', an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the optometrist. If in the opinion of the optometrist the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

Use of Medicare cards in bulk-billing

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

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

Assignment of benefit forms

Only the approved assignment of benefit forms available from the Department of Human Services website, www.humanservices.gov.au, can be used to bulk-bill patients for optometric services and no other form can be used without its approval.

(a) **Form DB2-OP**
This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy.

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

The Claim for Assigned Benefits (Form DB1N, DB1H)

Optometrists who accept assigned benefits must claim from the Department of Human Services using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to

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

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

Time limits applicable to lodgement of bulk bill claims for benefits

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

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

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

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

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

General

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

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

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

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

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

What is a referral?

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

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

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

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

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

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

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

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

Period for which referral is valid

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

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

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

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

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

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

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

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

Self referral

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

Lost, stolen or destroyed referrals

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

Emergency situations

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

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

AN.0.15 Residential Aged Care Facility Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)

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

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

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

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

AN.0.16 Provision for Review of the Schedule

Optometric Benefits Consultative Committee (OBCC)

The OBCC is an advisory committee established in 1990 by arrangement between the Minister and Optometry Australia.

The OBCC's functions are:

(a) to discuss the appropriateness of existing Medicare Benefits Schedule items for the purposes of considering whether an approach to the Medical Services Advisory Committee may be needed;

(b) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;

(c) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the *Health Insurance Act 1973* and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;

(d) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

The OBCC comprises two representatives from the Department of Health, two representatives from the Department of Human Services, and three representatives from Optometry Australia.

AN.0.17 Attendances at Hospitals, Residential Aged Care Facility and Institutions and Home Visits

To facilitate assessment of the correct Medicare rebate in respect of a number of patients attended on the one occasion at one of the above locations, it is important that the total number of patients seen be recorded on each

individual account, receipt or assignment form. For example, where ten patients were visited (for a brief consultation) in the one residential aged care facility on the one occasion, each account, receipt or assignment form would show "Item 20 - 1 of 10 patients" for a General Practitioner.

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

AN.0.18 Provision for Review of Practitioner Behaviour

Professional Services Review (PSR) Scheme

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

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

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

Following a review, the Director must:

(a) decide to take no further action; or

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

(c) refer the matter to a PSR Committee.

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

The Committee is authorised to:

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

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

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

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

(i) a reprimand;

(ii) counselling;

(iii) repayment of Medicare benefits; and/or

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

Further information on the Professional Services Review is available at www.psr.gov.au and information on Medicare compliance is available at http://www.humanservices.gov.au/health-professionals/subjects/compliance?utm_id=9.

Penalties

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

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

Medicare Participation Review Committee (MPRC)

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

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

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

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

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

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

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

Guidelines for the After Hours Other Medical Practitioners (AHOMPs) Program are available on the Department of Health's website.

After-hours attendance items may be claimed as follows:

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

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

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

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

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

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

Urgent After-Hours Attendances (Items 585 - 600)

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

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

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

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

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

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

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

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

Appendix B of the Approved Medical Deputising Service (AMDS) Program Guidelines offers a useful protocol to determine whether prospective after-hours patients should be seen by a deputising medical practitioner or see their regular medical practitioner. The AMDS Program Guidelines are available at http://www.health.gov.au/internet/main/publishing.nsf/Content/approved-medical-deputising-service

If the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to and specially open the consulting rooms for the attendance.

MBS Item 585 is available to medical practitioners who are:

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

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

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

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

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

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

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

MBS Item 588 is available to non-vocationally recognised medical practitioners who are providing services (as a contractor, employee, member or otherwise) for a general practice or clinic or as part of medical deputising arrangements in Modified Monash Model Areas 3 to 7.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

MBS item 591 is available to non-vocationally recognised medical practitioners who perform attendances for after-hours clinics or as part of deputising arrangements in Modified Monash Model Areas 1 and 2.

If more than one patient is seen on the same occasion (that is, the second and any further services are consequential to the first service) using either MBS items 585, 588 or 591, **MBS item 594** must be used in respect of the second and subsequent services to patients attended on the same occasion.

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

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

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

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

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

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

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

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

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

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

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

Non-Urgent After-Hours Attendances (5000 - 5067 and 5200 - 5267)

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

Non-Urgent After-Hours Attendances at a Place Other than Consulting Rooms (Other than a Hospital or Residential Aged Care Facility) (items 5003, 5023, 5043, 5063, 5220, 5223, 5227 and 5228) and *Non-Urgent After-Hours Attendances in a Residential Aged Care Facility* (Items 5010, 5028, 5049, 5067, 5260, 5263, 5265 and 5267) are to be used for non-urgent attendances on 1 or more patients on 1 occasion on a public holiday, on a Sunday, or before 8am and after 12 noon on a Saturday, or before 8am and after 6pm on any other day.

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

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

AN.0.20 Visiting Optometrists Scheme (VOS)

Special arrangements exist under the provisions of Section 129A of the Health Insurance Act 1973 to ensure that people in rural and remote locations have access to optometry services. Optometrists are encouraged to provide outreach services to national priority locations, particularly remote and very remote locations, Aboriginal and Torres Strait Islander communities and rural locations with an identified need for optometry services.

Under these arrangements, financial assistance may be provided to cover costs associated with delivering outreach services, including travel, accommodation and meals and facility fees.

Funding agreements are currently in place with optometrists for the delivery of services until 30 June 2015. Enquiries can be directed to vos@health.gov.au.

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

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

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

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

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

AN.0.22 Telehealth Patient-end Support Services by Optometrists

These notes provide information on the telehealth MBS attendance items for optometrists to provide clinical support to their patients, when clinically relevant, during video consultations with ophthalmologists under items 10945, 10946, 10947 and 10948 in Group A10.

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

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

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

Clinical indications

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

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

Collaborative Consultation

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

Restrictions

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

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are areas that are outside a Major City (RA1) according to ASGC-RA (RA2 - 5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference. This rule will not apply to specialist video consultations with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the *Health Insurance Act 1973*, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at:
http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/connectinghealthservices-eligible-geo.

Record Keeping

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

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

Multiple attendances on the same day

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

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

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

Aftercare Rule

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

Referrals

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

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the ophthalmologist. If the ophthalmologist is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

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

Duration of attendance

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

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

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

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

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

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

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

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

REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN

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

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

History

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

Examination

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

Diagnosis

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

Management plan

Treatment options/Treatment plan

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

Medication recommendations

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

Social measures

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

Other non medication measures

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

Indications for review

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

Longer term management

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

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

AN.0.24 Referred patient assessment, diagnosis and treatment and management plan for autism or any other pervasive developmental disorder (items 135 and 289)

These items are for consultant paediatricians (item 135) or psychiatrists (item 289), on referral from a medical practitioner, to provide early diagnosis and treatment of autism or any other pervasive development disorder (PDD) for children aged under 13 years. The items are for assessment, diagnosis and the creation of a treatment and management plan, and are claimable only once per patient per lifetime.

When item 135 or item 289 is in place, a consultant paediatrician or psychiatrist can refer a child with autism or other PDD to eligible allied health professionals for treatment services.

A child can access either the allied health services for autism/other PDD (using item 135 or 289) or for disability (using item 137 or 139), but not both.

If a child sees a consultant paediatrician or psychiatrist other than the one who put the treatment and management plan in place, the consultant paediatrician or psychiatrist who is seen subsequently can refer the child for any remaining allied health treatment services that are available to the child.

Children with an existing treatment and management plan created under item 135 or 289 can be reviewed under attendance items for consultant psychiatrists and paediatricians.

Where the patient presents with another morbidity in addition to autism or other PDD,item 132 can also be used for development of a treatment and management plan. However, the use of this item will not provide access to Medicare rebateable allied health services for treatment of autism or any other PDD.

Items 135 or 289 also provide a referral pathway for access to services provided through Childhood Autism Advisors by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). For

further information on assistance available through FaHCSIA, phone 1800 778 581 or emailASD.Support@fahcsia.gov.au. TTY users - phone 1800 555 677 then ask for the 1800 toll-free number you wish to contact.

Referral requirements

Items 135 (paediatrician) or 289 (psychiatrist) are for diagnosis and treatment of autism or any other PDD where clinically appropriate, including referral to allied health treatment services.

A course of treatment for the allied health treatment services consists of the number of allied health services stated on the child's referral, up to a maximum of 10 services. This enables the referring practitioner to consider a report from the allied health professional(s) about the services provided to the child, and the need for further treatment.

Within the maximum service allocation of twenty treatment services, the allied health professional(s) can provide one or more courses of treatment. Patients will require a separate referral for each allied health professional they are referred to and they will also need new referrals for each new course of treatment.

In addition to referrals to allied health treatment services, a consultant paediatrician or psychiatrist can refer a child to an eligible allied health provider to assist with diagnosis of the child or for the purpose of contributing to the child's pervasive developmental disorder (PDD). Referrals for these allied health assessment services can be made by a consultant paediatrician or psychiatrist as an outcome of the service provided under one of items 110-131 or 296-370 inclusive.

Referrals are only valid when prerequisite MBS services have been provided. If the referring service has not yet been claimed, the Department of Human Services (DHS) will not be aware of the child's eligibility and Medicare benefits cannot be paid. Providers can call DHS on 132 150 to confirm whether a relevant MBS service has been claimed and/or the number of allied health services already claimed by the child.

Referring medical practitioners are not required to use a specific form to refer patients for the allied health services that are available through the *Helping Children with Autism* program. The referral may be a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Allied health assistance with diagnosis/assessment and treatment

Helping Children with Autism Program - Allied Health Items

MBS items for allied health assessment and treatment of autism/PDD	***Allied health provider***
*Assistance with diagnosis / contribution to a treatment plan**	
82000	Psychologist
82005	Speech pathologist
82010	Occupational therapist
82030	Audiologist, optometrist, orthoptist, physiotherapist
*Treatment services***	
82015	Psychologist
82020	Speech pathologist
82025	Occupational therapist
82035	Audiologist, optometrist, orthoptist, physiotherapist

* Prerequisite MBS items: 110-131 (paediatrician) or items 296-370 (psychiatrist).
** Prerequisite MBS items: 135 (paediatrician) or 289 (psychiatrist).

Assessment services

Assessment services are available for an allied health provider to assist the referring practitioner with diagnosis or for contributing to a child's treatment and management plan. These services can be accessed by children aged under 13 years.

Medicare rebates are available for up to four allied health services in total per eligible child.

An allied health professional can provide these services when:

- the child has previously been provided with any MBS service covering items 110-131 inclusive by a consultant paediatrician; or
- the child has previously been provided with any MBS service covering items 296-370 (excluding item 359) inclusive by a consultant psychiatrist.

The four allied health assessment services may consist of any combination of items 82000, 82005, 82010 and 82030.

It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

Treatment services

Treatment services can be accessed when a child with autism or other PDD is aged under 15 years and has had a treatment and management plan put in place for them before their 13th birthday.

Medicare rebates are available for up to twenty allied health treatment services in total per eligible child.

An eligible allied health professional can provide these services when:

- the child has previously been provided with a treatment plan (item 135) by a consultant paediatrician; or
- the child has previously been provided with a treatment plan (item 289) by a consultant psychiatrist.

The twenty treatment services may consist of any combination of items 82015, 82020, 82025 or 82035.

It is the responsibility of the referring practitioner to allocate these services in keeping with the child's individual treatment needs and to refer the child to appropriate allied health professional(s) accordingly.

Existing patients or patients with an existing diagnosis

Where a specific plan has not been created previously for the treatment and management of autism or any other PDD, a new plan can be developed by the treating practitioner under item 135 or 289 where it is clinically appropriate to treat the patient under such a plan.

Children with an existing treatment and management plan created under item 135 or 289 can be reviewed under attendance items for consultant psychiatrists and paediatricians.

AN.0.25 Patient Assessment, Diagnosis and Treatment and Management Plan for a Child with Disability (Items 137 and 139)

Items 137 and 139 are for specialists and consultant physicians (137) or for general practitioners (139) to provide early diagnosis and treatment of children with any of the following conditions:

(a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction.

(b) hearing impairment that results in:

(i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or

(ii) permanent conductive hearing loss and auditory neuropathy.

(c) deafblindness

(d) cerebral palsy

(e) Down syndrome

(f) Fragile X syndrome

(g) Prader-Willi syndrome

(h) Williams syndrome

(i) Angelman syndrome

(j) Kabuki syndrome

(k) Smith-Magenis syndrome

(l) CHARGE syndrome

(m) Cri du Chat syndrome

(n) Cornelia de Lange syndrome

(o) microcephaly if a child has:

(i) a head circumference less than the third percentile for age and sex; and

(ii) a functional level at or below 2 standard deviations below the mean for age on a standard developmental test, or an IQ score of less than 70 on a standardised test of intelligence.

(p) Rett's disorder

"Standard developmental test" refers to the Bayley Scales of Infant Development or the Griffiths Mental Development Scales; "standardised test of intelligence" refers to the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI). It is up to the clinical judgement of the diagnosing practitioner if other tests are appropriate to be used.

Items 137 and 139 are for assessment, diagnosis and the creation of a treatment and management plan, and are claimable only once per patient per lifetime.

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

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

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

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

· current active medical problems

· past medical history;

· medication review;

· immunisation status;

· advance care planning arrangements;

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

· psychological function including cognition and mood; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AN.0.29 Acupuncture (Item 173, 193, 195, 197 and 199)

The service of "acupuncture" must be performed by a medical practitioner and itemised under item 173, 193, 195, 197 or 199 to attract benefits. These items cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

Items 193, 195, 197 and 199 may only be performed by a general practitioner, (see Note 4 of 'Medicare Benefit Arrangements' for a definition) if the Medicare Australia CEO has received a written notice from the Royal Australian College of General Practitioners (RACGP) stating that the person meets the skills requirements for providing services to which the items apply.

Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service "acupuncture" is provided.

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

For more information on the content-based item structure used in this Group, see A.5 in the explanatory notes.

AN.0.30 Consultant Psychiatrist - Initial consultations for NEW PATIENTS (Items 296 to 299 and 361) Referred Patient Assessment and Management Plan (Items 291, 293 and 359) and referral to Allied Mental Health Professionals

Referral for items 291, 293 and 359 should be through the general practitioner or participating nurse practitioner for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP or participating nurse practitioner.

In order to facilitate ongoing patient focussed management, an outcome tool will be utilised during the assessment and review stage of treatment, where clinically appropriate. The choice of outcome tools to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

- Kessler Psychological Distress Scale (K10)

- Short Form Health Survey (SF12)

- Health of the Nation Outcome Scales (HoNOS)

Preparation of the management plan should be in consultation with the patient. If appropriate, a written copy of the management plan should be provided to the patient. A written copy of the management plan should be provided to the general practitioner within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the GP or participating nurse practitioner may be appropriate. A guide to the content of the report which should be provided to the GP or participating nurse practitioner under this item is included within this Schedule.

It is expected that item 291 will be a single attendance. However, there may be particular circumstances where a patient has been referred by a GP or participating nurse practitioner for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, items 296, 297, 299 or 361 (for a new patient) or 300-308 (for continuing patients) may be used, and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item

requirements) prior to the consultation for providing the referring practitioner with an assessment and management plan. It is not intended that items 296, 297, 299, 361 or 300-308 will generally or routinely be used in conjunction with, or prior to, item 291.

Items 293 and 359 are available in instances where the GP or participating nurse practitioner initiates a review of the plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines

Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs. An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org

REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN

Preliminary

- The following content outline is indicative of what would usually be sent back to GPs or participating nurse practitioner.

- The Management plan should address the specific questions and issues raised by the GP or participating nurse practitioner

- In most cases the patient is usually well known by the GP or participating nurse practitioner

History and Examination

This should focus on the presenting symptoms and current difficulties, including precipitating and ongoing stresses; and only briefly mention any relevant aspects of the patient's family history, developmental history, personality features, past psychiatric history and past medical history.

It should contain a comprehensive relevant Mental Status Examination and any relevant pathology results if performed.

It should summarise any psychological tests that were performed as part of the assessment.

Diagnosis

A diagnosis should be made either using ICD 10 or DSM IV classification. In some cases the diagnosis may differ from that stated by the GP or participating nurse practitioner, and an explanation of why the diagnosis differs should be included.

Psychiatric formulation

A brief integrated psychiatric formulation focussing on the biological, psychological and physical factors. Any precipitant and maintaining factors should be identified including relevant personality factors. Protective factors should also be noted. Issues of risk to the patient or others should be highlighted.

Management plan

1. ***Education*** - Include a list of any handout material available to help people understand the nature of the problem. This includes recommending the relevant RANZCP consumer and carer clinical practice guidelines.

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

3. ***Psychotherapy -*** Recommendations should be given on the most appropriate mode of psychotherapy required, such as supportive psychotherapy, cognitive and behavioural psychotherapy, family or relationship therapy or intensive explorative psychotherapy. This should include recommendations on who should provide this therapy.

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

5. ***Other non medication measures -*** This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations, discussion of any complementary medicines, reading recommendations, relationship with other support services or agencies etc.

6. ***Indications for re-referral -*** It is anticipated that the majority of patients will be able to be managed effectively by the GP or participating nurse practitioner using the plan. If there are particular concerns about the possible need for further review, these should be noted.

7. ***Longer term management -*** Provide a longer term management plan listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as a relapse signature and relapse drill, and should include drug doses and other indicated interventions, expected response times, adverse effects and interactions.

Initial Consultation for a NEW PATIENT (item 296 in rooms, item 297 at hospital, item 299 for home visits and 361 for telepsychiatry)

The rationale for items 296 - 299 and 361 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for items 296 - 299 and 361 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician.

It is intended that either item 296, 297, 299 or 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist, **unless** the patient is referred by a medical practitioner practising in general practice or participating nurse practitioner for an assessment and management plan, in which case the consultant psychiatrist, if he or she agrees that the patient is suitable for management in a general practice setting, will use item 291 where an assessment and management plan is provided to the referring practitioner.

There may be particular circumstances where a patient has been referred by a GP or participating nurse practitioner to a consultant psychiatrist for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, item 296, 297, 299 or 361(for a new patient) or 300-308 (for continuing patients) may be used and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) and provides the referring practitioner with an assessment and management plan. It is not generally intended that item 296, 297, 299 or 361 will be used in conjunction with, or prior to, item 291.

Use of items 296 - 299 and 361 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

Items 300 - 308 are available for consultations in consulting rooms other than those provided under item 296, and items 291, 293 and 359. Similarly time tiered items remain available for hospital, home visits and telepsychiatry. These would cover a new course of treatment for patients who have already been seen by the consultant psychiatrist in the preceding 24 months as well as subsequent consultations for all patients.

Referral to Allied Mental Health Professionals (for new and continuing patients)

To increase the clinical treatment options available to psychiatrists and paediatricians for which a Medicare benefit is payable, patients with an assessed mental disorder (dementia, delirium, tobacco use disorder and mental

retardation are not regarded as mental disorders for the purposes of these items) may be referred, to an allied mental health professional for a total of ten individual allied mental health services in a calendar year. The ten services may consist of: psychological therapy services (items 80000 to 80015) - provided by eligible clinical psychologists; and/or focussed psychological strategies - allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165) - provided by eligible psychologists, occupational therapists and social workers.

Referrals from psychiatrists and paediatricians to an allied mental health professional must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Within the maximum service allocation of ten services, the allied mental health professional can provide one or more courses of treatment. For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral). These services should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year.

While such referrals are likely to occur for new patients seen under items 296 - 299 and 361, they are also available for patients at any point in treatment (from items 293 to 370), as clinically required, under the same arrangements and limitations as outlined above. The referral may be in the form of a letter or note to an eligible allied health professional signed and dated by the referring practitioner.

Patients will also be eligible to claim up to ten services within a calendar year for group therapy services involving 6-10 patients to which items 80020 (psychological therapy - clinical psychologist), 80120 (focussed psychological strategies - psychologist), 80145 (focussed psychological strategies - occupational therapist) and 80170 (focussed psychological strategies - social worker) apply. These group services are separate from the individual services and do not count towards the ten individual services per calendar year maximum associated with those items.

AN.0.31 Psychiatric Attendances (Item 319)

Medicare benefits are attracted under Item 319 only where patients are diagnosed as suffering from:

- severe personality disorder (predominantly from cluster B groupings), or in persons under 18 years of age a severe disruption of personality development; or
- anorexia nervosa; or
- bulimia nervosa; or
- dysthymic disorder; or
- substance-related disorder; or
- somatoform disorder; or
- a pervasive developmental disorder (including autism and Asperger's disorder)

according to the relevant criteria set out in the Diagnostic and Statistical Manual of the American Psychiatric Association - Fourth Edition (DSM-IV).

It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment. Once a patient is identified as meeting the criteria of item 319, he/she continues to be eligible under that item for the duration of the current course of treatment (provided that attendances under **items 300 to 308 and 319** do not exceed

160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to item 319 is the patient's score as assessed during the new course of treatment.

In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.

It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. the Department of Human Services will be closely monitoring the use of item 319.

When a patient who meets the criteria defined in item 319 attends a psychiatrist on more than 160 occasions in a calendar year, such attendances would be covered by items 310 to 318.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has undertaken to establish an appropriate mechanism to enable use of item 319 by suitably trained psychiatrists. In the interim it is expected that psychiatrists whose usual practice includes long term intensive treatment of patients whose diagnoses meet the criteria defined in the item will be using item 319.

On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in a calendar year. In this regard, the Department of Human Services will be monitoring providers' practice patterns with a view to the referral of possible cases of inappropriate practice to the Director of Professional Services Review.

AN.0.32 Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352)

Items 348 and 350 refer to investigative interviews of a patient's relatives or close associates to determine whether the particular problem with which the patient presented was focused in the patient or in the interaction between the patient and the person being interviewed. These items do not cover counselling of family or friends of the patient. The term "in the course of initial diagnostic evaluation of the patient" should normally be interpreted as extending for up to one month from the date of the initial consultation. There is no strict limit to the number of interviews or persons interviewed in that period. These items should not be used for interviews concerned with the continuing management of the patient.

Item 352 refers to investigative interviews of a patient's relatives or close associates to focus on a particular clinically relevant problem arising in the continuing management of the patient. This item does not cover counselling of family or friends of the patient. The payment of Medicare benefits under this item is limited to four in any twelve month period.

Benefits are payable for Item 348, 350 or 352 and for a consultation with a patient (items 300 - 328) on the same day provided that separate attendances are involved.

For Medicare benefit purposes, charges relating to services covered by items 348, 350 and 352 should be raised against the patient rather than against the person interviewed.

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

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

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

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

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

AN.0.34 Contact Lenses (Items 10801-10809)

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

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

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

(b) sporting purposes;

(c) work purposes; or

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

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

AN.0.35 Refitting of Contact Lenses (Item 10816)

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

AN.0.36 Health Assessments (Items 701, 703, 705, 707)

There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

Brief Health Assessment (MBS Item 701)

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard Health Assessment (MBS Item 703)

A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

Long Health Assessment (MBS Item 705)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged Health Assessment (MBS Item 707)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

General practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

MBS Items 701, 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

Target Group	Frequency of Service
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

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

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

a. information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
b. making an overall assessment of the patient;
c. recommending appropriate interventions;
d. providing advice and information to the patient;
e. keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
f. offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

A health assessment may only be claimed by a general practitioner.

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the general practitioner, or a general practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

A health assessment should not take the form of a health screening service.

A copy of the Health Assessment must be retained for a period of 2 years after the date of service.

MBS health assessment items 701, 703, 705, 707 must be provided by a general practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a general practice or health service, may assist general practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the general practitioner. This may include activities associated with:

- information collection; and

- providing patients with information about recommended interventions at the direction of the general practitioner.

The general practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

General practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 701, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 701, 703, 705 and 707 can be claimed for services provided by general practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.

AN.0.37 Health Assessment provided as a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool

Items 701, 703, 705 and 707 may be used to undertake a type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes, as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

The aim of this health assessment is to review the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool has been developed to provide a basis for both health professionals and health consumers to assess the risk of type 2 diabetes. It consists of a short list of questions which, when completed, provides a guide to a patient's current level of risk of developing type 2 diabetes. The item scores and risk rating calculations in the tool have been developed using demographic, lifestyle, anthropometric and biomedical data from the 2000 Australian Diabetes, Obesity and Lifestyle baseline survey and the AusDiab 2005 follow-up study.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from the Department's prevention of diabetes web page.

Clinical risk factors that the general practitioner must consider when providing this health assessment include:

(a) lifestyle, such as smoking, physical inactivity and poor nutrition;

(b) biomedical risk factors, such as high blood pressure, impaired glucose metabolism and excess weight;

(c) any relevant recent diagnostic test results; and

(d) a family history of chronic disease.

The health assessment must include the following:

(a) evaluating a patient's high risk score, as determined by the Australian Type 2 Diabetes Risk Assessment Tool which has been completed by the patient within a period of 3 months prior to undertaking the health assessment;

(b) updating the patient's history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines;

(c) making an overall assessment of the patient's risk factors and of the results of relevant examinations and investigations;

(d) initiating interventions, if appropriate, including referral to a lifestyle modification program and follow-up relating to the management of any risk factors identified (further information is available at the Department's prevention of diabetes web page.); and

(e) providing the patient with advice and information (such as the Lifescript resources produced by the Department of Health), including strategies to achieve lifestyle and behaviour changes if appropriate (further information is available at the Department's Lifescript web page).

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to this health assessment. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a 'high' score result are eligible for the health assessment, and subsequent referral to the subsidised lifestyle modification programs if appropriate (further information is available at the Department's prevention of diabetes web page).

A health assessment for a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool may only be claimed once every three years by an eligible patient.

AN.0.38 Health Assessment provided for people aged 45-49 years who are at risk of developing chronic disease

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

For the purposes of this health assessment, a patient is at risk of developing a chronic disease if, in the clinical judgement of the attending general practitioner, a specific risk factor for chronic disease is identified.

Risk factors that the general practitioner can consider include, but are not limited to:

(a) lifestyle risk factors, such as smoking, physical inactivity, poor nutrition or alcohol use;

(b) biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or

(c) family history of a chronic disease.

A chronic disease or condition is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

If, after receiving this health assessment, a patient is identifed as having a high risk of type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the general practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient (further information is available at http://www.health.gov.au/preventionoftype2diabetes).

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from
http://www.health.gov.au/preventionoftype2diabetes

A health assessment for people aged 45-49 years who are at risk of developing chronic disease may only be claimed once by an eligible patient.

AN.0.39 Health Assessment provided for people aged 75 years and older

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people aged 75 years and older.

A health assessment for people aged 75 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and/or medical interventions as appropriate.

This health assessment must include:

(a) measurement of the patient's blood pressure, pulse rate and rhythm;

(b) an assessment of the patient's medication;

(c) an assessment of the patient's continence;

(d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;

(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;

(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.

(h) A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

AN.0.40 Health Assessment provided as a comprehensive medical assessment for residents of residential aged care facilities

Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility

This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

(a) making a written summary of the comprehensive medical assessment;

(b) developing a list of diagnoses and medical problems based on the medical history and examination;

(c) providing a copy of the summary to the residential aged care facility; and

(d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the *Aged Care Act 1997*, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.

A health assessment for the purpose of a comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

(a) on admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another residential aged care facility within the previous 12 months; and

(b) at 12 month intervals thereafter.

AN.0.41 Health Assessment provided for people with an intellectual disability

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people with an intellectual disability.

A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient [IQ]) and would benefit from assistance with daily living activities. Where general practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The health assessment provides a structured clinical framework for general practitioners to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventive health care required. The health assessment must include the following items as relevant to the patient or his or her representative:

(a) Check dental health (including dentition);

(b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);

(c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);

(d) Assess nutritional status (including weight and height measurements) and a review of growth and development;

(e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);

(f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);

- Advise carers of the common side effects and interactions.

- Consider the need for a formal medication review.

(g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;

(h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);

(i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;

(j) Consider the need for breast examination, mammography, cervical screening, testicular examination, lipid measurement and prostate assessment as for the general population;

(k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;

(l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;

(m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;

(n) Check for thyroid disease at least every two years (or yearly for patients with Down syndrome);

(o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;

(p) Assess or review treatment for co-morbid mental health issues;

(q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and

(r) Consider whether there are any signs of physical, psychological or sexual abuse.

A health assessment for people with an intellectual disability may be claimed once every twelve months by an eligible patient.

AN.0.42 Health Assessment provided for refugees and other humanitarian entrants

Items 701, 703, 705 and 707 may be used to undertake a health assessment for refugees and other humanitarian entrants.

The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival).

The health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services. This includes Refugees, Special Humanitarian Program and Protection Program entrants with the following visas:

Offshore Refugee Category including:

(a) 200 Refugee

(b) 201 In Country Special Humanitarian

(c) 203 Emergency rescue

(d) 204 Women at Risk

(e) Offshore - Special Humanitarian Program

(f) 202 Global Special Humanitarian

Offshore - Temporary Humanitarian Visas (THV) including:

(g) Subclass 695 (Return Pending)

(h) Subclass 070 (Removal Pending Bridging)

Onshore Protection Program including:

(i) 866 Permanent Protection Visa (PPV)

(j) 785 Temporary Protection Visa (TPV)

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, general practitioners may telephone the Department of Human Services on 132011, with the patient present, to check eligibility.

The general practitioner and patient can use the service of a translator by accessing the Commonwealth Government's Translating and Interpreting Service (TIS) and the Doctors Priority Line. To be eligible for the fee-free TIS and Doctors Priority Line, the medical examiner must be in a private practice and provide a Medicare service to patients who do not speak English and are permanent residents.

A health assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

AN.0.43 Health Assessment for Aboriginal and Torres Strait Islander People (MBS Item 715)

This health assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

· An Aboriginal or Torres Strait Islander child who is less than 15 years.

· An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.

· An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

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

MBS item 715 must include the following elements:

(a) information collection, including taking a patient history and undertaking examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient; and

(e) keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and

(f) offering the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

If, after receiving this health assessment, a patient who is aged fifteen years and over but under the age of 55 years, is identified as having a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the general practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from http://www.health.gov.au/preventionoftype2diabetes

A health assessment may only be claimed by a general practitioner.

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment, "usual doctor" means the general practitioner, or a general practitioner working in the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

The Health Assessment for Aboriginal and Torres Strait Islander People is not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

A health assessment should not take the form of a health screening service (see General Explanatory Notes G.13.1).

MBS health assessment item 715 must be provided by a general practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners employed and/or otherwise engaged by a general practice or health service, may assist general practitioners in performing this health assessment. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the general practitioner. This may include activities associated with:

- information collection; and

- providing patients with information about recommended interventions at the direction of the general practitioner.

The general practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

General practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Item 715 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 715 can be claimed for services provided by general practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment provided to an Aboriginal and Torres Strait Islander person, provided the conditions of item 10990 and 10991 are satisfied.

The Health Assessment for Aboriginal and Torres Strait Islander People may be provided once every 9 months.

AN.0.44 A Health Assessment for an Aboriginal and Torres Strait Islander child (less than 15 years of age)

An Aboriginal and Torres Strait Islander child health assessment must include:

a. a personal attendance by a general practitioner;
b. taking the patient's medical history, including the following:
    i. mother's pregnancy history;
    ii. birth and neo-natal history:
    iii. breastfeeding history;
    iv. weaning, food access and dietary history;
    v. physical activity;
    vi. previous presentations, hospital admissions and medication usage;
    vii. relevant family medical history;
    viii. immunisation status;
    ix. vision and hearing (including neonatal hearing screening);
    x. development (including achievement of age appropriate milestones);
    xi. family relationships, social circumstances and whether the person is cared for by another person;
    xii. exposure to environmental factors (including tobacco smoke);
    xiii. environmental and living conditions;
    xiv. educational progress;
    xv. stressful life events;
    xvi. mood (including incidence of depression and risk of self-harm);
    xvii. substance use;
    xviii. sexual and reproductive health; and
    xix. dental hygiene (including access to dental services).
c. examination of the patient, including the following:
    i. measurement of height and weight to calculate body mass index and position on the growth curve;
    ii. newborn baby check (if not previously completed);

iii. vision (including red reflex in a newborn);
iv. ear examination (including otoscopy);
v. oral examination (including gums and dentition);
vi. trachoma check, if indicated;
vii. skin examination, if indicated;
viii. respiratory examination, if indicated;
ix. cardiac auscultation, if indicated;
x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;
xi. assessment of parent and child interaction, if indicated; and
xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular:
i. haemoglobin testing for those at a high risk of anaemia; and
ii. audiometry, if required, especially for those of school age
e. assessing the patient using the information gained in the child health check; and
f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

AN.0.45 A health assessment for an Aboriginal and Torres Strait Islander adult (aged between 15 years and 54 years)

An Aboriginal and Torres Strait Islander adult health assessment must include:

a. a personal attendance by a general practitioner;
b. taking the patient's medical history, including the following:
i. current health problems and risk factors;
ii. relevant family medical history;
iii. medication usage (including medication obtained without prescription or from other doctors);
iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;
v. sexual and reproductive health;
vi. physical activity, nutrition and alcohol, tobacco or other substance use;
vii. hearing loss;
viii. mood(including incidence of depression and risk of self-harm); and
ix. family relationships and whether the patient is a carer, or is cared for by another person;
x. vision
c. examination of the patient, including the following:
i. measurement of the patient's blood pressure, pulse rate and rhythm;
ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;
iii. oral examination (including gums and dentition);
iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and
v. urinalysis (by dipstick) for proteinurea;
vi. eye examination; and
d. undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):
i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;
ii. cervical screening;
iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35years); and
iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).
e. assessing the patient using the information gained in the adult health assessment; and

f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and
b. offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment;

AN.0.46 A health assessment for an Aboriginal and Torres Strait Islander older person (aged 55 years and over)

An Aboriginal and Torres Strait Islander Older Person's health assessment must include:

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

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and
b. offering the patient a written report on the health assessment, with
c. recommendations on matters covered by the health assessment; and
d. offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

AN.0.47 Chronic Disease Management Items (Items 721 to 732)

Description	*Item No*	*Minimum claiming period**
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility	729	3 months
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	731	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

* CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Regulatory requirements

Items 721, 723, 729, 731 and 732 provide rebates to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 585, 588, 591, 594, 599, 600, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227 and 5228 with chronic disease management items 721, 723, or 732 is not permitted for the same patient, on the same day.

Patient eligibility

In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table (GMST) mandates the following eligibility criteria:

CDM items 721, 723 and 732

These are:

· available to:

i. patients in the community; and
ii. private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

· not available to:

i. public in-patients of a hospital; or
ii. care recipients in a residential aged care facility.

CDM item 729

This is:

· available to:

i. patients in the community;
ii. both private and public in-patients being discharged from hospital.

· not available to care recipients in a residential aged care facility.

CDM item 731

This item is available to care recipients in a residential aged care facility only.

Item 721

A comprehensive written plan must be prepared describing:

a. the patient's health care needs, health problems and relevant conditions;
b. management goals with which the patient agrees;
c. actions to be taken by the patient;
d. treatment and services the patient is likely to need;
e. arrangements for providing this treatment and these services; and
f. arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider must:

a. explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and
b. record the plan; and
c. record the patient's agreement to the preparation of the plan; and
d. offer a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
e. add a copy of the plan to the patient's medical records.

A copy of the written plan must be retained for 2 years.

Item 723

When coordinating the development of Team Care Arrangements (TCAs), the general practitioner must:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and
b. prepare a document that describes:
    i. treatment and service goals for the patient;
    ii. treatment and services that collaborating providers will provide to the patient; and
    iii. actions to be taken by the patient;
    iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and
c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
d. discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and
e. record the patient's agreement to the development of TCAs;
f. give copies of the relevant parts of the document to the collaborating providers;
g. offer a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
h. add a copy of the document to the patient's medical records.

The document described above must be retained for 2 years.

One of the minimum two service providers collaborating with the GP can be another medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 729

A multidisciplinary care plan means a written plan that:

a. is prepared for a patient by:
    i. a general practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or
    ii. a collaborating provider (other than a general practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the general practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

A copy of the written plan must be retained for 2 years.

Item 731

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

a. is prepared for a patient by a collaborating provider (other than a general practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and
b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the general practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or
b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 731 can also be used for contribution to a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider (not being a service associated with a service to which items 735 to 758 apply).

Item 732

An "associated general practitioner" is a general practitioner who, if not engaged in the same general practice as the general practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the general practitioner must:

a. explain to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees) the steps involved in the review;
b. record the patient's agreement to the review of the plan;
c. review all the matters set out in the relevant plan;
d. make any required amendments to the patient's plan;
e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees);
f. add a copy of the amended document to the patient's records; and
g. provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the general practitioner must:

a. explain the steps involved in the review to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees);
b. record the patient's agreement to the review of the TCAs or plan;
c. consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the general practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;
d. make any required amendments to the patient's plan;
e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the general practitioner considers it appropriate and the patient agrees);
f. provide for further review of the amended plan by a date specified in the plan;
g. give copies of the relevant parts of the amended plan to the collaborating providers; and
h. add a copy of the amended document to the patient's records.

A copy of the amended plan must be retained for 2 years.

Item 732 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan (former item 720) or to COORDINATE REVIEW OF A Discharge Care Plan (former item 722), where these services were coordinated or prepared by that general practitioner (or an associated general practitioner), and not being a service associated with a service to which items 735-758 apply.

Claiming of benefits

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 732 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 732 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

· **Non electronic Medicare claiming of items 732 on the same date**
The time that each item 732 commenced should be indicated next to each item

· **Electronic Medicare claiming of item 732 on the same date**
Medicare Easyclaim*:* use the 'ItemOverrideCde" set to 'AP', which flags the item as *not duplicate services*
Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as *not duplicate*

Items 721, 723 and 732

The GP Management Plan items (721 and 732) and the Team Care Arrangement items (723 and 732) can not be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems

Items 721-732 should generally be undertaken by the patient's **usual general practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

A **practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional** may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

· individual allied health services (items 10950 to 10970); and/or

· group allied health services (items 81100 to 81125).

More information on eligibility requirements can be found in the explanatory note for individual allied health services and group allied health services.

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

The Department of Human Services (DHS) has developed two guidelines, the Health Practitioner Guideline to substantiate the preparation of a valid GP Management Plan (for medical practitioners) and the Health Practitioner Guideline to substantiate the coordination of the development of Team Care Arrangements (for medical practitioners) which are both located on the DHS website.

AN.0.48 Medicare Dental Items For Patients With Chronic Conditions And Complex Care Needs - Services Provided By A Dental Practitioner On Referral From A GP [Items 85011-87777]

Closure of Medicare Dental Items 85011-87777

The Medicare Chronic Disease Dental Scheme closed on 30 November 2012. No Medicare benefits will be payable for any dental services provided under Medicare dental items 85011-87777 provided after this date. The cost of any future dental services will need to be met by the patient.

Further details regarding the closure are available at www.health.gov.au/dental.

AN.0.49 Multidisciplinary Case Conferences by General Practitioners - (Items 735 to 758)

Items 735 to 758 provide rebates for general practitioners to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items **735, 739 and 743**, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and

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

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

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items **747, 750 and 758**, the provider must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the general practitioner's participation in the conference; and

(b) record the patient's agreement to the general practitioner's participation; and

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

(d) record the names of the participants; and

(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

ADDITIONAL INFORMATION

Usual general practitioner

Items 735-758 should generally be undertaken by the patient's usual general practitioner. This is a general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Multidisciplinary case conference team members

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference

Organisation and coordination of a multidisciplinary discharge case conference (items 735, 739 and 743) may be provided for private in-patients being discharged into the community from hospital.

Further sources of information

Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

AN.0.50 Public Health Medicine - (Items 410 to 417)

Attendances by public health physicians will attract Medicare benefits under the new items only where the attendance relates to one or more of the following: -

(i) management of a patient's vaccination requirements for accepted immunisation programs; or

(ii) prevention or management of sexually transmitted disease; or

(iii) prevention or management of disease due to environmental hazards or poisons; or

(iv) prevention or management of exotic diseases; or

(v) prevention or management of infection during outbreaks of infectious disease.

For more information on the content-based item structure used in this Group, see A.5 in the explanatory notes.

AN.0.51 Case Conferences by Consultant Physician - (Items 820 to 838, 6029 to 6034 and 6064 to 6075)

Items 820, 822, 823, 825, 826, 828, 6029, 6031, 6032, 6034, 6064, 6065, 6067, 6068, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Items 820, 822, 823, 825, 826 and 828 do not apply to an in-patient of a hospital.

For items 830, 832, 834, 835, 837 and 838, a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 830, 832, 834, 835, 837 and 838 are payable not more than once for each hospital admission.

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

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

-discusses a patient's history;

-identifies the patient's multidisciplinary care needs;

- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

-identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and

-assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068 (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of four.

For the purposes of items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient's usual General Practitioner) can be counted toward the minimum of three.

For the purposes of items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068 (that is, where a consultant physician organises a case conference), and items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074 and 6075 (that is, where a consultant physician participates in a case conference) "formal care providers" includes:

-the patient's usual General Practitioner;

-allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and

-community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

For items 820, 822, 823, 830, 832, 834, 6029, 6031, 6032, 6034, 6064, 6065, 6067 and 6068, organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:

(a)explaining to the patient or the patient's agent the nature of a case conference, and asking the patient or the patient's agent whether he or she agrees to the case conference taking place; and

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

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

(d)recording the names of the participants; and

(e)putting a copy of that record in the patient's medical records; and

(f) giving the patient or the patient's agent, and each other member of the team a summary of the conference; and

(h)giving a copy of the summary of the conference to the patient's usual general practitioner; and

(i) discussing the outcomes of the patient or the patient's agent.

Organisation of a discharge case conference (items 830, 832 and 834), may be provided for private in-patients only, and must be organised by the medical practitioner who is providing in-patient care.

Participation in a case conference

For items 825, 826, 828, 835, 837, 838, 6035, 6037, 6038, 6042, 6071, 6072, 6074, 6075. participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:

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

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

See Health Insurance (General Medical Services Table) Regulation, Division 2.21.

General requirements

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

A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants and to the patient's usual general practitioner.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the consultant physician should:

-Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;

- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;

-Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with Items 734 to 779.

The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point G.7.1 of the General Explanatory Notes for further details on billing procedures.

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

This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.0.52 Medication Management Reviews - (Items 900 and 903)

Item 900 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR’s are targeted at patients who are:

· currently taking five or more regular medications;

· taking more than 12 doses of medication per day;

· have had significant changes made to medication treatment regimen in the last three months;

· taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;

· experiencing symptoms suggestive of an adverse drug reaction;

· displaying sub-optimal response to treatment with medicines;

· suspected of non-compliance or inability to manage medication related therapeutic devices;

· having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;

· attending a number of different doctors, both general practitioners and specialists; and/or

· recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, general practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

· Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;

· Is subject to a chronic condition and/or complex medication regimen; and

· Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the general practitioner can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a general practitioner must, with the patient's consent:

(a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and

(c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and

(d) develop a written medication management plan following discussion with the patient; and

(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Claiming

A DMMR includes all DMMR-related services provided by the general practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review, only item 900 may be claimed.

If the general practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the general practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient's usual general practitioner. This is the general practitioner, or a general practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the general practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of **referral to a community pharmacy or an accredited pharmacist** includes:

· Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

· Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the general practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.

· A DMMR referral form is available for this purpose. If this form is not used, the general practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

The **discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist** includes:

· Receiving a written report from the reviewing pharmacist; and

· Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and

· Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of **a written medication management plan following discussion with the patient** includes:

· Developing a draft medication management plan and discussing this with the patient; and

· Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

Item 903 - Residential Medication Management Review

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

Patient eligibility

RMMRs are available to:

new residents on admission into a RACF; and

existing residents on an 'as required' basis, where in the opinion of the resident's general practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

REGULATORY REQUIREMENTS

When conducting a RMMR, a GP must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

A general practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and general practitioner agree that issues arising out of the review should be considered in a case conference.

A RMMR comprises all activities to be undertaken by the general practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

Claiming

A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

· any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;

· any subsequent follow up should be treated as a separate consultation item;

· an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the general practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the general practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE

A RMMR should generally be undertaken by the resident's 'usual GP'. This is the general practitioner, or a general practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable time-frame. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's general practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be

identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

The general practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The general practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

Related Items: **900 903**

AN.0.53 Taking a Cervical Screen from a Person who is Unscreened or Significantly Under-screened - (Items 2497 - 2509 and 2598 - 2616)

The item numbers 2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613 and 2616 should be used in place of the usual attendance item where as part of a consultation, a sample for cervical screening is collected from a person between the ages of 24 years and 9 months and 74 years inclusive who has not had a cervical smear in the last four years. Cervical Screening in accordance with the National Cervical Screening Policy at P.16.11.

Self collection of a sample for screening is only available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e. being 4 years since their last Pap test). Self collection should only be offered to an eligible person who refuses to have a sample collected by their requesting practitioner.

When providing this service, the doctor must satisfy themselves that the person has not had a cervical screening test in the last four years by:

(a) asking the person if they can remember having a cervical screening test in the last four years;

(b) checking their own practice's medical records; and

(c) checking the National Cancer Screening Register.

A person from the following groups are more likely than the general population to be unscreened or significantly underscreened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older people.

Vault smears are not eligible for items 2497 - 2509 and 2598 - 2616.

In addition to attracting a Medicare rebate, the use of these items will initiate a Cervical Screening SIP through the PIP.

A PIP Cervical Screening SIP is available for taking a cervical screen from a person who has not been screened in the last for four years. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Cervical Screening Incentive. A further PIP Cervical Screening Incentive payment is paid to practices which reach target levels of cervical screening for their patients aged 24 years and 9 months of age to 74 years inclusive. More detailed information on the PIP Cervical Screening Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or from the Department of Human Services website.

AN.0.54 Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus - (Items 2517 - 2526 and 2620 - 2635)

The item numbers 2517, 2518, 2521, 2522, 2525, 2526, and 2620, 2622, 2624, 2631, 2633, 2635, should be used in place of the usual attendance item when a consultation completes the minimum requirements of the annual Diabetes Cycle of Care for a patient with established diabetes mellitus.

The annual Diabetes Cycle of Care must be completed over a period of 11 months and up to 13 months, and at a minimum must include:

Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out*	At least once every two years
Measure weight and height and calculate BMI**	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet***	At least twice every cycle of care
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Test for estimated Glomerular Filtration Rate (eGFR)	At least once every year
Provide self-care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of Medication	Medication review

* Not required if the patient is blind or does not have both eyes.

** Initial visit: measure height and weight and calculate BMI as part of the initial assessment.

Subsequent visits: measure weight.

*** Not required if the patient does not have both feet.

These requirements are generally based on the current general practice guidelines produced by Diabetes Australia and the Royal Australian College of General Practitioners (Diabetes Management in General Practice). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.

Use of these items certifies that the minimum requirements of the Diabetes Cycle of Care have been completed for a patient with established diabetes mellitus in accordance with the guidelines above.

These items should only be used once per cycle per patient of either A18 Subgroup 2 or A19 Subgroup 2. For example, if item 2517 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same cycle.

The requirements for claiming these items are the minimum needed to provide good care for a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

In addition to attracting a Medicare rebate, recording a completion of a Diabetes Cycle of Care through the use of these items will initiate a Diabetes Service Incentive Payment (SIP) through the Practice Incentives Program (PIP).

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Diabetes Cycle of Care.

A PIP Diabetes SIP is available for completing the minimum requirements of the Diabetes Cycle of Care for individual patients as specified above. The Diabetes SIP is only paid once every 11-13 month period per patient. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Diabetes Incentive. A further PIP Diabetes Incentive payment is paid to practices which reach target levels of care for their patients with diabetes mellitus. More detailed information on the PIP Diabetes Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or the Department of Human Services website.

AN.0.55 Completion of the Asthma Cycle of Care - (Items 2546 - 2559 and 2664 - 2677)

The item numbers 2546, 2547, 2552, 2553, 2558, 2559 and 2664, 2666, 2668, 2673, 2675 and 2677 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the Asthma Cycle of Care. The Practice Incentives Program (PIP) Asthma Incentive is for patients with moderate to severe asthma who in the opinion of the doctor could benefit from review, eg those whose asthma management could be improved.

At a minimum the Asthma Cycle of Care must include:

- At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation),

- Documented diagnosis and assessment of level of asthma control and severity of asthma,

- Review of the patient's use of and access to asthma-related medication and devices,

- Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records),

- Provision of asthma self-management education to the patient, and

- Review of the written or documented asthma action plan.

The Asthma Cycle of Care should be provided to a patient by one GP or in exceptional circumstances by another GP within the same practice. In most cases, this will be the patient's usual medical practitioner. Completion of the Asthma Cycle of Care does not preclude referral to a specialist, but a specialist consultation cannot be counted as one of the two visits.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient-held written asthma action plan.

These items will only be payable for the completion of one Asthma Cycle of Care for each eligible patient per 12 month period, unless a further Asthma Cycle of Care is clinically indicated by exceptional circumstances.

If a subsequent Asthma Cycle of Care is indicated and the incentive item is to be claimed more than once per 12 month period for a patient, then the patient's invoice or Medicare voucher should be annotated to indicate that the Asthma Cycle of Care was required to be provided within 12 months of another Asthma Cycle of Care.

The minimum requirements of the Asthma Cycle of Care may be carried out in two (2) visits or if necessary as many visits as clinically required. The National Asthma Council's website provides a guide for completion of the Asthma Cycle of Care.

The visit that completes the Asthma Cycle of Care should be billed using the appropriate item listed in Group A18 Subgroup 3 and Group A19 Subgroup 3.

In addition to attracting a Medicare rebate, recording a completion of an Asthma Cycle of Care through the use of these items, will initiate an Asthma Service Incentive Payment (SIP) through the PIP.

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma Cycle of Care.

A PIP Asthma SIP is available for completing the minimum requirements of the Asthma Cycle of Care for individual patients as specified above. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP Asthma Incentive. More detailed information on the PIP Asthma Incentive is available from the Department of Human Services PIP enquiry line on 1800222032 or from the Department of Human Services website.

For more detailed information regarding asthma diagnosis, assessment and best practice management refer to the National Asthma Council's website.

Assessment of Severity

Generally, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

- Symptoms on most days, OR
- Use of preventer medication, OR
- Bronchodilator use at least 3 times per week, OR
- Hospital attendance or admission following an acute exacerbation of asthma.

Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used. Visit the National Asthma Council's website for more details.

AN.0.56 GP Mental Health Treatment Items - (Items 2700 to 2717)

This note provides information on the GP Mental Health Treatment items 2700, 2701, 2712, 2713, 2715 and 2717. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

Overview

The GP Mental Health Treatment items define services for which Medicare rebates are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80021) and allied mental health providers (items 80100 - 80171).

The GP Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

· assess and plan;

· provide and/or refer for appropriate treatment and services;

· review and ongoing management as required.

Who can provide

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by general practitioner. The term 'GP' is used in these notes as a generic reference to general practitioners able to claim these items.

Training Requirements (item 2715 and 2717)

GPs providing Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 2715 and 2717. For GPs who have not undertaken training, items 2700 and 2701 are available. Items 2715 provides for a Mental Health Treatment Plan lasting at least 20 minutes and item 2717 provides for a Mental Health Treatment Plan lasting at least 40 minutes. It is strongly recommended that GPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for GPs using these items.

What patients are eligible - Mental Disorder

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

These GP services are available to eligible patients in the community. GP Mental Health Treatment Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital. Where the GP who provides the GP Mental Health Treatment item is providing in-patient treatment the item is claimed as an in-hospital service (at 75% MBS rebate). GPs are able to contribute to care plans for patients using item 729, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 731.

PREPARING A GP MENTAL HEALTH TREATMENT PLAN - (Item 2700, 2701, 2715 or 2717)

What is involved - Assess and Plan

A rebate can be claimed once the GP has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the general practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement).

Assessment

An assessment of a patient must include:

· recording the patient's agreement for the GP Mental Health Treatment Plan service;

· taking relevant history (biological, psychological, social) including the presenting complaint;

· conducting a mental state examination;

· assessing associated risk and any co-morbidity;

· making a diagnosis and/or formulation; and

· administering an outcome measurement tool, except where it is considered clinically inappropriate.

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 2700, 2701, 2715 or 2717.

In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Treatment Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner. GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

Preparation of a GP Mental Health Treatment Plan

In addition to assessment of the patient, preparation of a GP Mental Health Treatment Plan must include:

· discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;

· identifying and discussing referral and treatment options with the patient, including appropriate support services;

· agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take;

· provision of psycho-education;

· a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;

· making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and

· documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained GP or allied mental health professional for provision of focussed psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through item 2700, 2701, 2715 or 2717 a patient is eligible to be referred for up to 10 Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

When referring patients GPs should provide similar information as per normal GP referral arrangements. This could include providing a copy of the patient's GP Mental Health Treatment Plan, where appropriate and with the patient's agreement. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the GP. For the purposes of the Medicare rebateable allied mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of six in any one referral). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The number of services that the patient is being referred for is at the discretion of the referring practitioner (eg. GP).

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 2712 or former item 2719).

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN - (Item 2712)

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

A rebate can be claimed once the GP who prepared the patient's GP Mental Health Treatment Plan (or another GP in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP Mental Health Treatment Plan by completing the activities that must be included in a review and meeting the relevant requirements listed under 'Additional Claiming Information'. The review item can also be used where a psychiatrist has prepared a referred assessment and management plan (item 291), as if that patient had a GP Mental Health Treatment Plan. The review service must include a personal attendance by the GP with the patient.

The review must include:

· recording the patient's agreement for this service;

· a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;

· modification of the documented GP Mental Health Treatment Plan if required;

· checking, reinforcing and expanding education;

· a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and

· re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of ongoing management.

The recommended frequency for the review service, allowing for variation in patients' needs, is:

· an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and

· if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item.

GP MENTAL HEALTH TREATMENT CONSULTATION - (Item 2713)

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health

Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

· taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);

· providing treatment, advice and/or referral for other services or treatment; and

· documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for Medicare rebateable services for focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291).

Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a GP is managing a patient under a referred psychiatrist assessment and management plan (item 291), a patient is eligible for up to 10 Medicare rebateable allied mental health services per calendar year for services by:

· clinical psychologists providing psychological therapies; or

· appropriately trained GPs or allied mental health professionals providing focussed psychological strategy (FPS) services.

In addition to the above services, patients will also be eligible to claim up to 10 separate services for the provision of group therapy.

When referring patients, GPs should provide similar information as per normal GP referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly identifying the specific number of sessions the patient is being referred for. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for an initial course of treatment (a maximum of six services in any one referral but may be less depending on the referral and the patient's clinical need). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The GP should consider the patient's clinical need for further sessions after the initial referral. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

In the instance where a patient has received the 10 psychological therapy services (items 80000 to 80021), focussed psychological services-allied mental health services (items 80100 to 80171) or GP focussed psychological strategies services (items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

ADDITIONAL CLAIMING INFORMATION

Before proceeding with any GP Mental Health Treatment Plan or Review service the GP must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

(b) the patient's agreement to proceed is recorded.

Before completing any GP Mental Health Treatment Plan or Review service and claiming a benefit for that service, the GP must offer the patient a copy of the treatment plan or reviewed treatment plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The GP may, with the permission of the patient, provide a copy of the GP Mental Health Treatment Plan, or relevant parts of the plan, to other providers involved in the patient's treatment.

The GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

· if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;

· if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and

· if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the GP and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

Links to other Medicare Services

It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

· Where a patient has a mental health condition only, it is anticipated that they will be managed under the new GP Mental Health Treatment items.

· Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used.

· Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the GP is able to use both the CDM items (for team-based care) and the GP Mental Health Treatment items.

The Department of Human Services (DHS) has developed a **Health Practitioner Guideline to substantiate the preparation of a valid GP Mental Health treatment Plan** which is located on the DHS website.

AN.0.57 Provision of Focussed Psychological Strategies - (Items 2721 to 2731)

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan, shared care plan or a psychiatrist assessment and management plan.

Minimum Requirements

All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with the Department of Human Services as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 2721 - 2731 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to 10 allied mental health services under these item numbers per calendar year. The 10 services may consist of: GP focussed psychological strategies services (items 2721 to 2731 or non-specialist medical practitioner items 283 to 287, 371 and 372); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

Out-of-Surgery Consultation

It is expected that this service would be provided only for patients who are unable to attend the practice.

Telehealth Consultation

A **telehealth eligible area** means an area that is a Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Specific Modified Monash locations can be looked up at DoctorConnect

Specific Focussed Psychological Strategies

A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education
(including motivational interviewing)
2. Cognitive-behavioural therapy including:
· **Behavioural interventions**
- Behaviour modification
- Exposure techniques
- Activity scheduling
· **Cognitive interventions**
- Cognitive therapy
3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing
4. Skills training

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. Interpersonal therapy

Mental Disorder

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care:ICD - 10 Chapter V Primary Health Care Version.

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

AN.0.58 Pain and Palliative Medicine (Items 2801 to 3093)

Attendance by a recognised specialist or consultant physician in the specialty of pain medicine (2801, 2806, 2814, 2824, 2832, 2840) and Case conference by a recognised specialist or consultant physician in the specialty of pain medicine (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000).

Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000, apply only to a service provided by a recognised specialist or consultant physician in the specialty of pain medicine, in relation to a pain patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

The conditions that apply to the Case Conferences items (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of pain medicine and that service is pain medicine, then the relevant items from the pain specialist group (2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) must be claimed. Services to patients who are not receiving pain medicine services should be claimed using the relevant attendance or case conferencing items.

Attendance by a recognised specialist or consultant physician in the specialty of palliative medicine (3005, 3010, 3014, 3018, 3023, 3028) and Case conference by a recognised specialist or consultant physician in the specialty of palliative medicine (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093).

Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, apply only to a service provided by a recognised specialist or consultant physician in the specialty of palliative medicine, in relation to a palliative patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

General Practitioners who are recognised specialist in the specialty of palliative medicine and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Management Plan items (721 and 732) or Team Care Arrangement items (723 and 732) for that patient. The referring practitioner is able to provide these services.

The conditions that apply to the Case Conferences items (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of palliative medicine and that service is a palliative medicine service, then the relevant items from the palliative specialist group 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) must be claimed. Services to patients who are not receiving palliative care services should be claimed using the relevant attendance or case conferencing items.

AN.0.59 Telepsychiatry - (Items 353 to 370)

Telepsychiatry is defined as electronic transmission of psychiatric consultations, advice or services in digital form from one location to another using a data communication link provided by a third party carrier, or carriers. It requires the providers to comply with the International Telecommunications Union Standards which cover all types of videoconferencing from massive bandwidth to internet use. If X-rays are required for a psychiatric consultation then the consultant psychiatrist must comply with the DICOM Standards.

Support and Resourcing

The Royal Australian and New Zealand College of Psychiatrists encourages best practice in telepsychiatry and to this end has developed a Telepsychiatry Position Statement. To obtain a copy of this document and/or further information, assistance and support, practitioners are able to contact the College by email cpd@ranzcp.org or by visiting www.ranzcp.org.

Duration of Telepsychiatry Consultation

For items 353 to 358 the **time** provides a range of options equal to those provided in items 300 to 308 to allow for the appropriate treatment depending on the requirements of the treatment plan.

Number of Consultations in a Calendar Year

Items 353 to 358 may only be claimed for up to a maximum of 12 consultations in aggregate for each patient in a calendar year. Items 364 to 370 are to be claimed where face-to-face consultations are clinically indicated. Items 364 to 370 must be used to ensure that Medicare payments continue for further telepsychiatry consultations.

If the number of attendances in aggregate to which items 296 to 299, 300 to 308, 353 to 358 and 361 to 370 apply exceeds 50 for a single patient in any calendar year, any further attendances on that patient in that calendar year would be covered by items 310 to 318.

Documenting the Telepsychiatry Session

For items 353 to 370 the psychiatrist must keep a record of the treatment provided during an episode of care via telepsychiatry sessions or face-to-face consultations and must convey this in writing to the referring practitioner after the first session and then, at a minimum, after every six consultations.

Geographical

Telepsychiatry items 353 to 361 are available for use when a referred patient is located in a regional, rural or remote area. A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

Referred Patient Assessment and Management Plan review (Item 359)

Referral for item 359 should be through the GP or participating nurse practitioner for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP or participating nurse practitioner. Item 359 is available in instances where the GP or participating nurse practitioner initiates a review of the management plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines` (Note: An electronic version of the Guidelines is available on the RANZCP website at www.ranzcp.org)

Initial Consultations for NEW PATIENTS (Item 361)

The rationale for item 361 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for item 361 may be from a participating nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician. It is intended that item 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist. It is not generally intended that item 361 will be used in conjunction with, or prior to, item 291.

The use of items 361 and 296-299 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

AN.0.60 Attendances by Medical Practitioners who are Emergency Physicians - (Items 501 to 536)

Items 501 to 536 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the ACEM.

Items 501 to 511 cover five categories of attendance based largely on the tasks undertaken in a recognised emergency medicine department of a private hospital by the practitioner during the attendance on the patient rather than simply on the time spent with the patient. The emergency department must be part of a hospital and this department must be licensed as an "emergency department" by the appropriate State government authority.

The attendances for items 501 to 515 are divided into five categories relating to the level of complexity, namely:

(i) Level 1

(ii) Level 2

(iii) Level 3

(iv) Level 4

(v) Level 5

To assist medical practitioners who are emergency physicians in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL 1

This item is for the obvious and straightforward cases and the practitioner's records would reflect this. In this context "limited examination", means examination of the affected part if required, and management of the action taken.

LEVEL 2

The description of this item introduces the words "expanded problem focussed history" and "formulation and documentation of a diagnosis and management plan in relation to one or more problems". In this context an "expanded problem focussed history" means a history relating to a specific problem or condition; and "formulation and documentation of a management plan" includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels 1 and 2 relate not to time but to complexity.

LEVEL 3

Further levels of complexity are implied in these terms by the introduction of "medical decision making of moderate complexity".

LEVEL 4

This item covers more difficult problems requiring the taking of a "detailed history" and "detailed examination of one or more systems", with or without liaison with other health care professionals and subsequent discussion with the patient, his or her agent and/or relatives.

LEVEL 5

This item covers the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they are performed. These items also cover cases which need prolonged discussion. It involves the taking of a comprehensive history, comprehensive examination and involving medical decision making of high complexity.

In relation to the time in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

AN.0.61 Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition - (Items 519 to 536)

The conditions to be met before services covered by items 519 to 536 attract benefits are:

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

(ii) the times relate to the total time spent with a single patient, even if the time spent by the physician is not continuous.

AN.0.62 Case Conferences by Consultant Psychiatrists - (Items 855 to 866)

A range of new items has been introduced for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital in-patients. These items are introduced to improve the effectiveness of psychiatric case conferences and make it easier for psychiatrists to work with general practitioners and allied health professionals, thereby ensuring better coordinated care for patients. Three new items (855, 857 and 858) cover the organisation of a community case conference and a further three (861, 864 and 866) cover the organisation of a discharge case conference. Where a consultant psychiatrist organises a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant psychiatrist and one other medical practitioner (other than a specialist or a consultant physician) are counted towards the minimum of three.

Items 855, 857, and 858 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 855, 857, and 858 do not apply to an in-patient of a hospital.

For items 861, 864 and 866 a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital. Items 861, 864 or 866 are payable not more than once for each hospital admission.

The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

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

- discusses a patient's history;

- identifies the patient's multidisciplinary care needs;

- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;

- identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and assesses whether previously identified outcomes (if any) have been achieved.

For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and one of whom must be the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.

The patient's carer may be included as a member of the team (See A.49.8 below), in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

For the purposes of items 855 to 866 a consultant psychiatrist should generally be the consultant psychiatrist that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

For the purposes of A.49.5, "formal care provider" includes in addition to the consultant psychiatrist and a medical practitioner (other than a specialist or consultant physician):

- allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

- home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The involvement of a patient's carer, such as a friend or family member, in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the consultant psychiatrist should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The involvement of the patient's carer is not counted towards the minimum of three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement. However, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

Organisation of a case conference

Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

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

- recording the patient's agreement to the case conference; and

- recording the day on which the conference was held, and the times at which the conference started and ended; and

- recording the names of the participants; and

- recording the matters mentioned in A.49.4 and putting a copy of that record in the patient's medical records; and

- offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and

- discussing the outcomes of the case conference with the patient.

General requirements

In circumstances where the patient's usual medical practitioner, is not available to be a member of the case conference team, another medical practitioner known to the patient may be substituted.

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

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

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

- Inform the patient that 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. 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)

AN.0.63 Case Conference by Consultant Physicians in Geriatric/Rehabilitation Medicine - (Item 880)

Item 880 applies only to a service provided by a consultant physician or a specialist in the specialty of Geriatric or Rehabilitation Medicine who has completed the additional requirements of the Royal Australasian College of Physicians for recognition in the subspecialty of geriatric medicine or rehabilitation medicine. The service must be in relation to an admitted patient in a hospital (not including a patient in a residential aged care facility) who is receiving one of the following types of specialist care:

· geriatric evaluation and management (GEM), in which the clinical intent is to maximise health status and/or optimise the living arrangements for a patient with multidimensional medical conditions with disabilities and psychosocial problems, who is usually (but not always) an older patient; or

· rehabilitation care, in which the clinical intent is to improve the functional status of a patient with an impairment or disability.

Both types of care are evidenced by multi-disciplinary management and regular assessments against a plan with negotiated goals and indicative time-frames. A case conference is usually held on each patient once a week

throughout the patient's admission, usually as part of a regular scheduled team meeting, at which all the inpatients under the consultant physician's care are discussed in sequence.

The specific responsibilities of the coordinating consultant physician or specialist are defined as:

- coordinating and facilitating the multidisciplinary team meeting;
- resolving any disagreement or conflict so that management consensus can be achieved;
- clarifying responsibilities; and
- ensuring that the input of participants and the outcome of the case conference is appropriately recorded.

The multidisciplinary team participating in the case conference must include a minimum of three formal inpatient care providers from different disciplines, including at least two providers from different allied health disciplines (listed at dot point 2 of A24.7). The consultant physician or specialist is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner can be counted toward the minimum of three.

The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three formal inpatient care providers must be present for the whole of the case conference.

Prior informed consent must be obtained from the patient, or the patient's agent including informing the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

Item 880 is not payable more than once a week or on the same day as a claim for any of the physician discharge case conferencing items 830, 832, 834, 835, 837 and 838, in respect of a particular patient.

AN.0.64 Neurosurgery Specialist Referred Consultation - (Items 6007 to 6015)

Referred consultations provided by specialist neurosurgeons will be covered under items 6007 to 6015. These new items replace the use of specialist items 104 and 105 for referred consultations by neurosurgeons.

The neurosurgical consultation structure comprises an initial consultation (item 6007) and four categories of subsequent consultations (items 6009-6015). These categories relate to the time AND level of complexity of the attendance i.e

(i) Level 1 - 6009

(ii) Level 2 - 6011

(iii) Level 3 - 6013

(iv) Level 4 - 6015

The following provides further guidance for neurosurgeons in utilising the appropriate items in common clinical situations:

(i) Initial consultation item 6007 will replace item 104.

(ii) Subsequent consultation items 6009-6015 will replace item 105

Item 6009 (subsequent consultation on a patient for 15 mins or less) covers a minor subsequent attendance which is straightforward in nature. Some examples of a minor attendance would include consulting with the patient for the purpose of issuing a repeat script for anticonvulsant medications or the routine review of a patient with a ventriculo-peritoneal shunt.

Item 6011 (subsequent consultation on a patient for a duration of between 16 to 30 mins) would involve an detailed and comprehensive examination of the patient which is greater in complexity than would be provided under item 6009, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Where a

management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record included in the patient notes. Some examples of a detailed neurosurgical attendance would include:

· the reviewing of neuroimaging for the monitoring of a tumour or lesion and discussion of the results with the patient (e.g. meningiomaglioma, spinal cord tumour);

· consultation on a patient to review imaging for spinal cord/cauda equina/ nerve root compression from a disc prolapse and discussion of results; or

· consultation on a patient prior to insertion of a ventriculo-peritoneal shunt)

Item 6013 (subsequent consultation on a patient with complex neurological conditions for the duration of between 31 to 45 mins) should involve a extensive and comprehensive examination of the patient greater in complexity than under item 6011, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Item 6013 would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record be included in the patient notes. Some examples of an extensive neurosurgical attendance would include:

· an attendance on a patient prior to a craniotomy for cerebral tumour;

· surgery for spinal tumour;

· revision of spinal surgery;

· epilepsy surgery; or

· for the treatment of cerebral aneurysm.

Examination of such patients would include full cranial nerve examination or examination of upper and lower limb nervous system.

Item 6015 (subsequent consultation on a patient with complex neurological conditions for a duration of more than 45 mins) should involve an exhaustive examination of the patient that is more comprehensive than 6013 and any ordering or evaluation of investigations and include detailed relevant patient notes. It would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is thoroughly discussed with the patient and a written record be included in the patient notes. An exhaustive neurosurgical consultation includes:

· managing adverse neurological outcomes;

· detailed discussion when multiple modalities are available for treatment (e.g. clipping versus coiling for management of a cerebral aneurysm, surgical resection versus radiosurgery for cerebral tumour); or

· discussion where surgical intervention is likely to result in a neurological deficit but surgery is critical to patient's life or to stop progressive neurologic decline (e.g. cranial nerve dysfunction, motor dysfunction secondary to a cerebral or spinal cord lesion).

Examination of such patients would include exhaustive neurosurgical examination includings full neurological examination (cranial nerves and limbs) or detailed 'focused examination' (e.g.: brachial plexus examination)

Complex neurosurgical problems referred to in items 6013 and 6015 include:

· deterioration in neurologic function following cranial or spinal surgery;

· presentation with new neurologic signs/symptoms; multifocal spinal and cranial disease (e.g. neurofibromatosis); or

· chronic pain states following spinal surgery (including discussion of other treatment options and referral to pain management)

NOTE: It is expected that informed financial consent be obtained from the patient where possible.

AN.0.65 Cancer Care Case Conference - (Items 871 and 872)

For the purposes of these items:

· private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;

· the billing general practitioner, specialist or consultant physician may be from any area of medical practice and must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item.

· only one practitioner is eligible to claim item 871 for each patient case conference. This should be the doctor who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating doctor.

· each billing practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;

· participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;

· suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietician; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or, speech pathologist;

· in general, it is expected that no more than two case conferences per patient per year will be billed by a practitioner; and

· cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes eg community or discharge case conferences.

AN.0.66 Non-directive Pregnancy Support Counselling Service - (Item 4001)

Overview

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is:

· pregnant; or

· who has been pregnant in the 12 months preceding the first service to which this item, item 792 or item 81000, 81005 or 81010 applies in relation to that pregnancy.

There are five MBS items for the provision of non-directive pregnancy support counselling services:

Item 4001 - services provided by an eligible GP. The term 'GP' is used hereafter as a generic reference to general practitioners;

Item 792 – services provided by an eligible medical practitioner (not including a specialist or consultant physician)

Item 81000 - services provided by an eligible psychologist;

Item 81005 - services provided by an eligible social worker; and

Item 81010 - services provided by an eligible mental health nurse.

This notes relate to provision of a non-directive pregnancy support counselling service by an eligible GP.

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

The service involves the GP undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

Medicare rebates for non-directive pregnancy support counselling services provided using item 4001 are available to a person who is:

- pregnant; or
- who has been pregnant in the 12 months preceding the first service to which this item, item 792 or item 81000, 81005 or 81010 applies in relation to that pregnancy.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items - 792, 4001, 81000, 81005 and 81010.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with the Department of Human Services on 132 011. Alternatively, the GP may check with the Department of Human Services (although the patient must be present to give permission).

Item 10990 or item 10991 can also be claimed in conjunction with item 4001 provided the conditions of the relevant item, 10990 or 10991, are satisfied.

Minimum Requirements

This service may only be provided by a GP who has completed appropriate non-directive pregnancy counselling training.

AN.0.67 Telehealth Patient-end Support Services by Health Professionals

These notes provide information on the telehealth MBS attendance items for general practitioners, specialists and consultant physicians to provide clinical support to their patients, when clinically relevant, during video consultations with specialists or consultant physicians under items 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199 and 2220 in Group A30.

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

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

A video consultation will involve a single specialist or consultant physician attending to the patient, with the participation of another general practitioner, specialist or consultant physician, at the patient end. The above time-tiered items provide for patient-end support services in various settings including, consulting rooms, other than consulting rooms, eligible residential aged care services and Aboriginal Medical Services.

Clinical indications

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

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

Collaborative Consultation

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

Restrictions

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

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which a direction, made under subsection 19(2) of the Health Insurance Act 1973, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

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

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

Multiple attendances on the same day

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

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

Extended Medicare Safety Net (EMSN)

Items which provide for telehealth patient-end support services are subject to EMSN caps equal to 300% of the schedule fee (to a maximum of $500). This is consistent with Government policy relating to capping EMSN for MBS consultation services.

Aftercare Rule

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

Referrals

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

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

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

Bulk billing

Bulk bill incentive items 10990 or 10991 may be billed in conjunction with the telehealth items 2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199 and 2220.

Duration of attendance

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

AN.0.68 Telehealth Specialist Services

These notes provide information on the telehealth MBS video consultation items by specialists, consultant physicians and psychiatrists. A video consultation involves a single specialist, consultant physician or psychiatrist attending a patient, with the possible support of another medical practitioner, a participating optometrist, a participating nurse practitioner, a participating midwife, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker at the patient end of the video conference. The decision as to whether the patient requires clinical support at the patient end of the specialist service is based on whether the support is necessary for the provision of the specialist service. Telehealth specialist services can be provided to patients when there is no patient-end support service provided.

MBS items numbers 99, 112, 149, 288, 389, 2820, 3015, 6016, 13210, 16399 and 17609 allow a range of existing MBS attendance items to be provided via video conferencing. These items have a derived fee which is equal to 50% of the schedule fee for the consultation item claimed (e.g. 50% of the schedule fee for item 104) when billed with one of the associated consultation items (such as 104). A patient rebate of 85% for the derived fee is payable.

Six MBS item numbers (113, 114, 384, 2799, 3003 and 6004) provide for an initial attendance via videoconferencing by a specialist, consultant physician, consultant occupational physician, pain medicine specialist/consultant physician, palliative medicine specialist/consultant physician or neurosurgeon where the service is 10 minutes or less. The items are stand-alone items and do not have a derived fee.

Where an attendance is more than 10 minutes, practitioners should use the existing item numbers consistent with the current arrangements. Normal restrictions which apply for initial consultations will also apply for these items. For example, if a patient has an initial consultation via telehealth, they cannot also claim an initial face-to-face consultation as part of the same course of treatment.

Clinical indications

The specialist, consultant physician or psychiatrist must be satisfied that it is clinically appropriate to provide a video consultation to a patient. The decision to provide clinically relevant support to the patient is the responsibility of the specialist, consultant physician or psychiatrist.

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

Restrictions

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

Billing Requirements

All video consultations provided by specialists, consultant physicians or psychiatrists must be **separately billed**. That is, only the relevant telehealth MBS consultation item and the associated derived item are to be itemised on the account/bill/voucher. Any other service/item billed should be itemised on a separate account/bill/voucher. This will ensure the claim is accurately assessed as being a video consultation and paid accordingly.

Practitioners should not use the notation 'telehealth', 'verbal consent' or 'Patient unable to sign' to overcome administrative difficulties to obtaining a patient signature for bulk billed claims (for further information see mbsonline.gov.au/telehealth).

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare are determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in a residential care service; or at an Aboriginal Medical Service or an Aboriginal Community Controlled Health Service for which a direction made under subsection 19(2) of the *Health Insurance Act 1973* as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/ telehealth eligible areas

Record Keeping

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

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

Extended Medicare Safety Net (EMSN)

All telehealth consultations (with the exception of the participating optometrist telehealth items) are subject to EMSN caps. The EMSN caps for ART and Obstetric telehealth items 13210 and 16399 were set in reference to the EMSN caps applying to the base ART and Obstetric consultation items.

The EMSN caps for all other telehealth consultation items are equal to 300% of the schedule fee (to a maximum of $500). The maximum EMSN benefit for a telehealth consultation is equal to the sum of the EMSN cap for the base item and the EMSN cap for the telehealth items.

Aftercare Rule

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

Multiple attendances on the same day

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

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

Referrals

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

Technical requirements

In order to fulfill the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a telehealth attendance is not payable.

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

AN.0.69 Australian Defence Force Post-discharge GP Health Assessment

Items 701, 703, 705 and 707 may be used to undertake a health assessment for a former serving member of the Australian Defence Force, including a former member of permanent and reserve forces.

A health assessment for a former serving member of the Australian Defence Force is an assessment of:

a. a patient's physical and psychological health and social function; and
b. whether health care, education and other assistance should be offered to the patient to improve their physical, psychological health or social function.

This health assessment must include:

a. a personal attendance by a general practitioner; and
b. taking the patient's history, including the following:
    i. the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;
    ii. the patient's social history, including relationship status, number of children (if any) and current occupation;
    iii. the patient's current medical conditions;
    iv. whether the patient suffers from hearing loss or tinnitus;
    v. the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;
    vi. the patient's smoking, if applicable;
    vii. the patient's alcohol use, if applicable;
    viii. the patient's substance use, if applicable;
    ix. the patient's level of physical activity;
    x. whether the patient has bodily pain;
    xi. whether the patient has difficulty getting to sleep or staying asleep;
    xii. whether the patient has psychological distress;
    xiii. whether the patient has posttraumatic stress disorder;
    xiv. whether the patient is at risk of harm to self or others;
    xv. whether the patient has anger problems;
    xvi. the patient's sexual health;
    xvii. any other health concerns the patient has.

The assessment must also include the following:

i. measuring the patient's height;
ii. weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;
iii. measuring the patient's waist circumference;
iv. taking the patient's blood pressure;
v. using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;
vi. either making the further assessment or referring the patient to another medical practitioner who can make the further assessment;
vii. documenting a strategy for improving the patient's health;
viii. offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures;
ix. keeping a record of the assessment.

A general practitioner may use the 'ADF Post-discharge GP Health Assessment Tool' as a screening tool for the health assessment. This assessment tool can be viewed on the At Ease portal of the Department of Veterans' Affairs' website at: http://at-ease.dva.gov.au. Other assessment tools mentioned in the Department of Veteran's Affairs Mental Health Advice Book may be relevant and can also be viewed on the At Ease portal.

This health assessment may only be claimed once by an eligible patient.

The health assessment must not be performed in conjunction with a separate consultation in relation to the patient unless the consultation is clinically necessary.

The health assessment must be performed by the patient's usual doctor.

AN.0.70 Limitation of items—certain attendances by specialists and consultant physicians

Medicare benefits are not payable for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6019, 6052 and 16404 when claimed in association with an item in group T8 with a schedule fee of $300 or more.

The restriction applies when the procedure is performed by the same practitioner, on the same patient, on the same day.

AN.0.71 General practitioner attendances and Aftercare

Vocationally and non-vocationally registered general practitioners providing post-operative treatment to a patient during an aftercare period are eligible for Medicare benefits. This rule applies only in the circumstance whereby the vocationally or non-vocationally registered general practitioner did not perform the initial procedure requiring post-operative treatment.

Normal aftercare rules still apply when it is the vocationally or non-vocationally registered general practitioner who rendered the initial procedure requiring post-operative treatment.

AN.7.1 Attendances by Medical Practitioners

Items 179 to 212, 214 to 220, 221 to 223, 224 to 228, 229 to 244, 245 to 249, 251 to 271, 272 to 287, 371, 372, 733 to 789, 792 and 812 to 892 relate to attendances rendered by a medical practitioner who is not a general practitioner, specialist or consultant physician, and who:

(a) is registered under section 3GA of the Act, to the extent that the person is practising during the period in respect of which, and in the location in respect of which, he or she is registered, and insofar as the circumstances specified for paragraph 19AA(3)(b) of the Act apply; or

(b) is covered by an exemption under subsection 19AB(3) of the Act; or

(c) first became a medical practitioner before 1 November 1996.

AN.7.2 Medical Practitioner Attendances To Which No Other Item Applies

Eligibility

Items 179 to 212 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A2.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

To assist medical practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

Professional consultation of not more than 5 minutes duration

The item will be used for obvious and straightforward cases and this should be reflected in the practitioner's records. In this context, the practitioner should undertake the necessary examination of the affected part if required, and note the action taken.

Professional consultation of more than 5 minutes but not more than 25 minutes

The item will be used for a consultation lasting more than 5 minutes but less than 25 minutes for cases that are not obvious or straightforward in relation to one or more health related issues. This should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Professional consultation of more than 25 minutes but not more than 45 minutes

The item will be used for a consultation lasting more than 25 minutes but less than 45 minutes for cases in relation to one or more complex health related issues. This should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Professional consultation of more than 45 minutes

The item will be used for a consultation lasting at least 40 minutes for cases in relation to one or more very complex health related issues. This should be reflected in the practitioner's record. In the item descriptor singular also means plural and vice versa.

Creating and Updating a Personally Controlled Electronic Health Record (PCEHR)

The time spent by a medical practitioner on the following activities may be counted towards the total consultation time:

- Reviewing a patient's clinical history, in the patient's file and/or the PCEHR, and preparing or updating a Shared Health Summary where it involves the exercise of clinical judgement about what aspects of the clinical history are relevant to inform ongoing management of the patient's care by other providers; or
- Preparing an Event Summary for the episode of care.

Preparing or updating a Shared Health Summary and preparing an Event Summary are clinically relevant activities. When either of these activities are undertaken with any form of patient history taking and/or the other clinically relevant activities that can form part of a consultation, the item that can be billed is the one with the time period that matches the total consultation time.

MBS rebates are not available for creating or updating a Shared Health Summary as a stand-alone service.

Recording Clinical Notes

In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance

Where, during the course of a single attendance by a medical practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see the General Explanatory Notes for further information on the interpretation of the Schedule).

AN.7.3 Medical Practitioner Prolonged Attendance in Treatment of a Critical Condition (Items 214 to 220)

The conditions to be met before services covered by items 214-220 attract benefits are:-

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

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

(iii) if personal attendance on a single patient is provided by 1 or more medical practitioners concurrently, each practitioner may claim an attendance fee.

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

AN.7.4 Medical Practitioner Family Group Therapy (Items 221, 222 and 223)

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

Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death certificates, cremation certificates, counselling of relatives (note - items 348, 350 and 352 are not counselling services), group attendances (other than group attendances covered by items 170, 171, 172, 221, 222, 223, 342, 344 and 346) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

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

AN.7.5 Medical Practitioner Health Assessments (Items 224 to 227)

There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

Brief Health Assessment (MBS Item 224)

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

Standard Health Assessment (MBS Item 225)

A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

Long Health Assessment (MBS Item 226)

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient's health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

Prolonged Health Assessment (MBS Item 227)

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

Medical practitioners may select one of the MBS health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient's presentation and the specific requirements that have been established for each target group eligible for health assessments.

MBS Items 224, 225, 226 and 227 may be used to undertake a health assessment for the following target groups:

Target Group	Frequency of Service
A type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	Once every three years to an eligible patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient
A health assessment for former serving members of the Australian Defence Force	Once only to an eligible patient

Frequency of service

The frequency with which patients in different population groups may receive a health assessment is described in the table above. Patients may not have more services than they are eligible for under the frequency provisions that apply to specific types of health assessment.

Important Note: patients may receive services using MBS items 224 to 227 and 701 to 707. However, once a patient has received a service using an MBS item from **either** group of MBS health assessment items, the patient may not receive another MBS health assessment until the appropriate time period has expired. In the case of health assessment services that are provided only once in a patient's lifetime, the patient would not be eligible for another health assessment.

The only exception is patients who are eligible for more than one type of health assessment (that is, the patient belongs to more than one eligible patient category). However, the frequency of service restrictions also apply to these services.

If a medical practitioner is not sure if a patient is eligible for an MBS health assessment service, they may telephone the Department of Human Services on 132011, with the patient present, to check eligibility.

Guidance Notes

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

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

a. information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;

b. making an overall assessment of the patient;

c. recommending appropriate interventions;

d. providing advice and information to the patient;

e. keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and

f. offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

Restrictions on billing the health assessment items

A health assessment may only be billed by a medical practitioner (not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the medical practitioner, or a medical practitioner working in the same medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

A health assessment should not take the form of a health screening service.

MBS health assessment items 224, 225, 226 and 227 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses or Aboriginal and Torres Strait Islander health practitioners, employed and/or otherwise engaged by a medical practice or health service, may assist medical practitioners in performing health assessments. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exception is the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 224, 225, 226 and 227 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 224, 225, 226 and 227 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment, provided the conditions of item 10990 and 10991 are satisfied.

AN.7.6 Medical Practitioner Health Assessment Provided as a Type 2 Diabetes Risk Evaluation for People Aged 40-49 Years with a High Risk of Developing Type 2 Diabetes as Determined by the Australian Type 2 Diabetes Risk Assessment Tool

Items 224, 225, 226 and 227 may be used to undertake a type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes, as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

The aim of this health assessment is to review the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool has been developed to provide a basis for both health professionals and health consumers to assess the risk of type 2 diabetes. It consists of a short list of questions which, when completed, provides a guide to a patient's current level of risk of developing type 2 diabetes. The item scores and risk rating calculations in the tool have been developed using demographic, lifestyle, anthropometric and biomedical data from the 2000 Australian Diabetes, Obesity and Lifestyle baseline survey and the AusDiab 2005 follow-up study.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from the Department's prevention of diabetes web page.

Clinical risk factors that the medical practitioner must consider when providing this health assessment include:

(a) lifestyle, such as smoking, physical inactivity and poor nutrition;

(b) biomedical risk factors, such as high blood pressure, impaired glucose metabolism and excess weight;

(c) any relevant recent diagnostic test results; and

(d) a family history of chronic disease.

The health assessment must include the following:

(a) evaluating a patient's high risk score, as determined by the Australian Type 2 Diabetes Risk Assessment Tool which has been completed by the patient within a period of 3 months prior to undertaking the health assessment;

(b) updating the patient's history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines;

(c) making an overall assessment of the patient's risk factors and of the results of relevant examinations and investigations; and

(d) initiating interventions, if appropriate, including referral to a lifestyle modification program and follow-up relating to the management of any risk factors identified (further information is available at the Department's prevention of diabetes web page).

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to this health assessment. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a 'high' score result are eligible for the health assessment, and subsequent referral to the subsidised lifestyle modification programs if appropriate (further information is available at the Department's prevention of diabetes web page).

A health assessment for a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool may only be claimed once every three years by an eligible patient.

AN.7.7 Medical Practitioner Health Assessment Provided for People Aged 45-49 Years Who are at Risk of Developing Chronic Disease

Items 224, 225, 226 and 227 may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

For the purposes of this health assessment, a patient is at risk of developing a chronic disease if, in the clinical judgement of the attending medical practitioner, a specific risk factor for chronic disease is identified.

Risk factors that the medical practitioner can consider include, but are not limited to:

(a) lifestyle risk factors, such as smoking, physical inactivity, poor nutrition or alcohol use;

(b) biomedical risk factors, such as high cholesterol, high blood pressure, impaired glucose metabolism or excess weight; or

(c) family history of a chronic disease.

A chronic disease or condition is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

If, after receiving this health assessment, a patient is identifed as having a high risk of type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the medical practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient (further information is available at http://www.health.gov.au/preventionoftype2diabetes).

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from http://www.health.gov.au/preventionoftype2diabetes.

A health assessment for people aged 45-49 years who are at risk of developing chronic disease may only be claimed once by an eligible patient.

AN.7.8 Medical Practitioner Health Assessment Provided for People Aged 75 Years and Older

Items 224, 225, 226 and 227 may be used to undertake a health assessment for people aged 75 years and older.

A health assessment for people aged 75 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and/or medical interventions as appropriate.

This health assessment must include:

(a) measurement of the patient's blood pressure, pulse rate and rhythm;

(b) an assessment of the patient's medication;

(c) an assessment of the patient's continence;

(d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;

(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;

(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.

(h) A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

AN.7.9 Medical Practitioner Health Assessment Provided as a Comprehensive Medical Assessment for Residents of Residential Aged Care Facilities

Items 224, 225, 226 and 227 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility

This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

(a) making a written summary of the comprehensive medical assessment;

(b) developing a list of diagnoses and medical problems based on the medical history and examination;

(c) providing a copy of the summary to the residential aged care facility; and

(d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the Aged Care Act 1997, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.

A health assessment for the purpose of a comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

(a) on admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another residential aged care facility within the previous 12 months; and

(b) at 12 month intervals thereafter.

AN.7.10 Medical Practitioner Health Assessment Provided for People with an Intellectual Disability

Items 224, 225, 226 and 227 may be used to undertake a health assessment for people with an intellectual disability.

A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient [IQ]) and would benefit from assistance with daily living activities. Where medical practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to practice in Australia (if the patient is a child) or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The health assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventive health care required. The health assessment must include the following items as relevant to the patient or his or her representative:

(a) Check dental health (including dentition);

(b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);

(c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);

(d) Assess nutritional status (including weight and height measurements) and a review of growth and development;

(e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);

(f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);

- Advise carers of the common side effects and interactions.
- Consider the need for a formal medication review.

(g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;

(h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);

(i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;

(j) Consider the need for breast examination, mammography, cervical screening, testicular examination, lipid measurement and prostate assessment as for the general population;

(k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;

(l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;

(m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;

(n) Check for thyroid disease at least every two years (or yearly for patients with Down syndrome);

(o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;

(p) Assess or review treatment for co-morbid mental health issues;

(q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and

(r) Consider whether there are any signs of physical, psychological or sexual abuse.

A health assessment for people with an intellectual disability may be claimed once every twelve months by an eligible patient.

AN.7.11 Medical Practitioner Health Assessment Provided for Refugees and Other Humanitarian Entrants

Items 224, 225, 226 and 227 may be used to undertake a health assessment for refugees and other humanitarian entrants.

The purpose of this health assessment is to introduce new refugees and other humanitarian entrants to the Australian primary health care system, as soon as possible after their arrival in Australia (within twelve months of arrival).

The health assessment applies to humanitarian entrants who are resident in Australia with access to Medicare services. This includes Refugees, Special Humanitarian Program and Protection Program entrants with the following visas:

Offshore Refugee Category including:

(a) 200 Refugee

(b) 201 In Country Special Humanitarian

(c) 203 Emergency rescue

(d) 204 Women at Risk

(e) Offshore - Special Humanitarian Program

(f) 202 Global Special Humanitarian

Offshore - Temporary Humanitarian Visas (THV) including:

(g) Subclass 695 (Return Pending)

(h) Subclass 070 (Removal Pending Bridging)

Onshore Protection Program including:

(i) 866 Permanent Protection Visa (PPV)

(j) 785 Temporary Protection Visa (TPV)

Patients should be asked to provide proof of their visa status and date of arrival in Australia. Alternatively, medical practitioners may telephone the Department of Human Services on 132011, with the patient present, to check eligibility.

The medical practitioner and patient can use the service of a translator by accessing the Commonwealth Government's Translating and Interpreting Service (TIS) and the Doctors Priority Line. To be eligible for the fee-free TIS and Doctors Priority Line, the medical examiner must be in a private practice and provide a Medicare service to patients who do not speak English and are permanent residents.

A health assessment for refugees and other humanitarian entrants may only be claimed once by an eligible patient.

AN.7.12 Medical Practitioner Australian Defence Force Post-Discharge Health Assessment

Items 224, 225, 226 and 227 may be used to undertake a health assessment for a former serving member of the Australian Defence Force, including a former member of permanent and reserve forces.

A health assessment for a former serving member of the Australian Defence Force is an assessment of:

- a patient's physical and psychological health and social function; and
- whether health care, education and other assistance should be offered to the patient to improve their physical, psychological health or social function.

This health assessment must include:

1. a personal attendance by a medical practitioner; and

2. taking the patient's history, including the following:

i the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;

ii the patient's social history, including relationship status, number of children (if any) and current occupation;

iii the patient's current medical conditions;

iv whether the patient suffers from hearing loss or tinnitus;

v the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;

vi the patient's smoking, if applicable;

vii the patient's alcohol use, if applicable;

viii the patient's substance use, if applicable;

ix the patient's level of physical activity;

x whether the patient has bodily pain;

xi whether the patient has difficulty getting to sleep or staying asleep;

xii whether the patient has psychological distress;

xiii whether the patient has posttraumatic stress disorder;

xiv whether the patient is at risk of harm to self or others;

xv whether the patient has anger problems;

xvi the patient's sexual health;

xvii any other health concerns the patient has.

The assessment must also include the following:

1. measuring the patient's height;

2. weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;

3. measuring the patient's waist circumference;

4. taking the patient's blood pressure;

5. using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;

6. either making the further assessment or referring the patient to another medical practitioner who can make the further assessment;

7. documenting a strategy for improving the patient's health;

8. offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures;

9. keeping a record of the assessment.

A medical practitioner may use the 'ADF Post-discharge GP Health Assessment Tool' as a screening tool for the health assessment. This assessment tool can be viewed on the At Ease portal of the Department of Veterans' Affairs' website at: http://at-ease.dva.gov.au. Other assessment tools mentioned in the Department of Veteran's Affairs Mental Health Advice Book may be relevant and can also be viewed on the At Ease portal.

This health assessment may only be claimed once by an eligible patient.

The health assessment must not be performed in conjunction with a separate consultation in relation to the patient unless the consultation is clinically necessary.

The health assessment must be performed by the patient's usual doctor.

AN.7.13 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander People (Item 228)

This health assessment is available to all people of Aboriginal and Torres Strait Islander descent and should be used for health assessments for the following age categories:

- An Aboriginal or Torres Strait Islander child who is less than 15 years.
- An Aboriginal or Torres Strait Islander person who is aged between 15 years and 54 years.
- An Aboriginal or Torres Strait Islander older person who is aged 55 years and over.

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

MBS item 228 must include the following elements:

(a) information collection, including taking a patient history and undertaking examinations and investigations as required;

(b) making an overall assessment of the patient;

(c) recommending appropriate interventions;

(d) providing advice and information to the patient; and

(e) keeping a record of the health assessment, and offering the patient, and/or patient's carer, a written report about the health assessment with recommendations about matters covered by the health assessment; and

(f) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

If, after receiving this health assessment, a patient who is aged fifteen years and over but under the age of 55 years, is identified as having a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the medical practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient.

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from http://www.health.gov.au/preventionoftype2diabetes

A health assessment may only be claimed by a medical practitioner (not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment, "usual doctor" means the medical practitioner, or a medical practitioner working in the same medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

The health assessment for Aboriginal and Torres Strait Islander People is not available to people who are in-patients of a hospital or care recipients in a residential aged care facility.

A health assessment should not take the form of a health screening service (see General Explanatory Notes G.13.1).

MBS health assessment item 228 must be provided by a medical practitioner personally attending upon a patient. Suitably qualified health professionals, such as practice nurses, Aboriginal health workers or Aboriginal and Torres Strait Islander health practitioners employed and/or otherwise engaged by a general practice or health service, may assist medical practitioners in performing this health assessment. Such assistance must be provided in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- information collection; and
- providing patients with information about recommended interventions at the direction of the medical practitioner.

The medical practitioner should be satisfied that the assisting health professional has the necessary skills, expertise and training to collect the information required for the health assessment.

Medical practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment).

Item 228 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, item 228 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with any health assessment provided to an Aboriginal and Torres Strait Islander person, provided the conditions of item 10990 and 10991 are satisfied.

An eligible patient may only receive the Health Assessment for Aboriginal and Torres Strait Islander People using either item 228 or item 715 once in a 9 month period.

AN.7.14 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Child less than 15 years of age (Item 228)

An Aboriginal and Torres Strait Islander child health assessment must include:

a. a personal attendance by a medical practitioner;

b. taking the patient's medical history, including the following:

i. mother's pregnancy history;

ii. birth and neo-natal history:

iii. breastfeeding history;

iv. weaning, food access and dietary history;

v. physical activity;

vi. previous presentations, hospital admissions and medication usage;

vii. relevant family medical history;

viii. immunisation status;

ix. vision and hearing (including neonatal hearing screening);

x. development (including achievement of age appropriate milestones);

xi. family relationships, social circumstances and whether the person is cared for by another person;

xii. exposure to environmental factors (including tobacco smoke);

xiii. environmental and living conditions;

xiv. educational progress;

xv. stressful life events;

xvi. mood (including incidence of depression and risk of self-harm);

xvii.substance use;

xviii. sexual and reproductive health; and

xix. dental hygiene (including access to dental services).

c. examination of the patient, including the following:

i. measurement of height and weight to calculate body mass index and position on the growth curve;

ii. newborn baby check (if not previously completed);

iii. vision (including red reflex in a newborn);

iv. ear examination (including otoscopy);

v. oral examination (including gums and dentition);

vi. trachoma check, if indicated;

vii. skin examination, if indicated;

viii. respiratory examination, if indicated;

ix. cardiac auscultation, if indicated;

x. development assessment, if indicated, to determine whether age appropriate milestones have been achieved;

xi. assessment of parent and child interaction, if indicated; and

xii. other examinations in accordance with national or regional guidelines or specific regional needs, or as indicated by a previous child health assessment.

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular:

i. haemoglobin testing for those at a high risk of anaemia; and

ii. audiometry, if required, especially for those of school age

e. assessing the patient using the information gained in the child health check; and

f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

AN.7.15 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Adult Aged 15 Years to 54 Years (Item 228)

An Aboriginal and Torres Strait Islander adult health assessment must include:

a. a personal attendance by a medical practitioner;

b. taking the patient's medical history, including the following:

i. current health problems and risk factors;

ii. relevant family medical history;

iii. medication usage (including medication obtained without prescription or from other doctors);

iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;

v. sexual and reproductive health;

vi. physical activity, nutrition and alcohol, tobacco or other substance use;

vii. hearing loss;

viii. mood(including incidence of depression and risk of self-harm);

ix. family relationships and whether the patient is a carer, or is cared for by another person; and

x. vision

c. examination of the patient, including the following:

i. measurement of the patient's blood pressure, pulse rate and rhythm;

ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;

iii. oral examination (including gums and dentition);

iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and

v. urinalysis (by dipstick) for proteinurea;

vi. eye examination;

d. undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):

i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;

ii. cervical screening;

iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35years); and

iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).

e. assessing the patient using the information gained in the adult health assessment; and

f. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and

b. offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment.

AN.7.16 Medical Practitioner Health Assessment for an Aboriginal and Torres Strait Islander Older Person Aged 55 Years and Over (Item 228)

An Aboriginal and Torres Strait Islander Older Person's health assessment must include:

a. a personal attendance by the medical practitioner;

b. measurement of the patient's blood pressure, pulse rate and rhythm;

c. an assessment of the patient's medication;

d. an assessment of the patient's continence;

e. an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;

f. an assessment of the patient's physical function, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3months;

g. an assessment of the patient's psychological function, including the patient's cognition and mood;

h. an assessment of the patient's social function, including:

i. the availability and adequacy of paid, and unpaid, help;

ii. whether the patient is responsible for caring for another person;

i. an eye examination

An Aboriginal and Torres Strait Islander Older Person's health assessment must also include:

a. keeping a record of the health assessment; and

b. offering the patient a written report on the health assessment, with

c. recommendations on matters covered by the health assessment; and

d. offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

AN.7.17 Medical Practitioner Chronic Disease Management (Items 229 to 233)

Description	Item No	Minimum claiming period*
Preparation of a GP Management Plan (GPMP)	229	12 months
Coordination of Team Care Arrangements (TCAs)	230	12 months
Contribution to a Multidisciplinary Care Plan, or to a Review of a	231	3 months

Multidisciplinary Care Plan, for a patient who is not a care recipient in a residential aged care facility		
Contribution to a Multidisciplinary Care Plan, or to a review of a multidisciplinary care plan, for a resident in an aged care facility	232	3 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	233	3 months

* CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient's clinical condition or care requirements that necessitates the performance of the service for the patient.

Regulatory requirements

Items 229, 230, 231, 232 and 233 provide rebates for medical practitioners to manage chronic or terminal medical conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months or is terminal.

Restrictions on claiming multiple Chronic Disease Management Items

Patients may receive chronic disease management services using MBS items 229 to 223 and 721 to 732. However, once a patient has received a service using an MBS item from **either** group of MBS chronic disease management items, the patient may not receive another MBS chronic disease management service until the minimum claiming period has expired. The only exception is where there are exceptional circumstances necessitating an earlier performance of the service (see **Claiming of benefits** below).

If a medical practitioner is not sure if a patient is eligible for an MBS chronic disease management service, they may telephone the Department of Human Services on 132011, with the patient present, to check eligibility.

Restriction of Co-claiming of Chronic Disease and General Consultation Items

Co-claiming of MBS general consultation items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 179, 181, 185, 187, 189, 191, 203, 206, 585, 588, 591, 594, 599, 600, 733, 737, 741, 745, 761, 763, 766, 769, 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228 with chronic disease management items 229, 230 and 233 is not permitted for the same patient, on the same day.

Patient eligibility

CDM items 229, 230 and 233 are available to:

i patients in the community; and

ii private in-patients of a hospital (including private in-patients who are residents of aged care facilities) being discharged from hospital.

CDM items 229, 230 and 233 are not available to:

i public in-patients of a hospital; or

ii care recipients in a residential aged care facility.

CDM item 231 is available to:

i patients in the community;

ii both private and public in-patients being discharged from hospital.

CDM item 231 is not available to:

i care recipients in a residential aged care facility.

CDM item 232 is available to care recipients in a residential aged care facility only.

Components of service

Item 229

A comprehensive written plan must be prepared describing:

a. the patient's health care needs, health problems and relevant conditions;

b. management goals with which the patient agrees;

c. actions to be taken by the patient;

d. treatment and services the patient is likely to need;

e. arrangements for providing this treatment and these services; and

f. arrangements to review the plan by a date specified in the plan.

In preparing the plan, the medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and

b. record the plan; and

c. record the patient's agreement to the preparation of the plan; and

d. offer a copy of the plan to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

e. add a copy of the plan to the patient's medical records.

Item 230

When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:

a. consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and

b. prepare a document that describes:

i treatment and service goals for the patient;

ii treatment and services that collaborating providers will provide to the patient; and

iii actions to be taken by the patient;

iv arrangements to review (i), (ii) and (iii) by a date specified in the document; and

c. explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

d. discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and

e. record the patient's agreement to the development of TCAs;

f. give copies of the relevant parts of the document to the collaborating providers;

g. offer a copy of the document to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

h. add a copy of the document to the patient's medical records.

One of the minimum two service providers collaborating with the medical practitioner can be another medical practitioner. The patient's informal or family carer can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

Item 231

A multidisciplinary care plan means a written plan that:

a. is prepared for a patient by:

i a medical practitioner in consultation with two other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or

ii a collaborating provider (other than a medical practitioner) in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

i. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

j. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 232

A multidisciplinary care plan in a Residential Aged Care Facility (RACF) means a written plan that:

a. is prepared for a patient by a collaborating provider (other than a medical practitioner, e.g. a RACF), in consultation with at least two other collaborating providers, each of whom provides a different kind of treatment or services to the patient; and

b. describes, at least, treatment and services to be provided to the patient by the collaborating providers.

When contributing to a multidisciplinary care plan or to a review of the care plan, the medical practitioner must:

a. prepare part of the plan or amendments to the plan and add a copy to the patient's medical records; or

b. give advice to a person who prepares or reviews the plan and record in writing, on the patient's medical records, any advice provided to such a person.

Item 232 can also be used for contribution to a multidisciplinary care plan prepared for a resident by another provider before the resident is discharged from a hospital or an approved day-hospital facility, or to a review of such a plan prepared by another provider (not being a service associated with a service to which items 235 to 240 apply).

Item 233

An "associated medical practitioner" is a medical practitioner who, if not engaged in the same general practice as the medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the medical practitioner must:

a. explain to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) the steps involved in the review;

b. record the patient's agreement to the review of the plan;

c. review all the matters set out in the relevant plan;

d. make any required amendments to the patient's plan;

e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

f. add a copy of the amended document to the patient's records; and

g. provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, a multidisciplinary community care plan or a multidisciplinary discharge care plan, the medical practitioner must:

a. explain the steps involved in the review to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

b. record the patient's agreement to the review of the TCAs or plan;

c. consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;

d. make any required amendments to the patient's plan;

e. offer a copy of the amended document to the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees);

f. provide for further review of the amended plan by a date specified in the plan;

g. give copies of the relevant parts of the amended plan to the collaborating providers; and

h. add a copy of the amended document to the patient's records.

Item 233 can also be used to COORDINATE A REVIEW OF a Multidisciplinary Community Care Plan or to COORDINATE REVIEW OF A Discharge Care, where these services were coordinated or prepared by that medical practitioner (or an associated medical practitioner), and not being a service associated with a service to which items 235 to 240 apply.

Claiming of benefits

Each service to which item 233 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice or Medicare voucher should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Payment can then be made.

Item 233 can be claimed twice on the same day providing an item 233 for reviewing a GP Management Plan and another 233 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the MBS item descriptors and explanatory notes.

Medicare requirements when item 233 is claimed twice on the same day

If a GPMP and TCAs are both reviewed on the same date and item 233 is to be claimed twice on the same day, both electronic claims and manual claims need to indicate they were rendered at different times:

Non electronic Medicare claiming of items 233 on the same date

The time that each item 233 commenced should be indicated next to each item

Electronic Medicare claiming of item 233 on the same date

Medicare Easyclaim: use the 'ItemOverrideCde" set to 'AP', which flags the item as not duplicate services
Medicare Online/ECLIPSE: set the 'DuplicateServiceOverrideIND' to 'Y', which flags the item as not duplicate

Items 229, 230 233

The GP Management Plan items (229 and 233) and the Team Care Arrangement items (230 and 233) cannot be claimed by medical practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

Additional information

Advice on the items and further guidance are available at http://www.health.gov.au/mbsprimarycareitems

Items 229-233 should generally be undertaken by the patient's usual medical practitioner. This means the medical practitioner, or a medical practitioner working in the same medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of medical services to the patient over the next twelve months. The term "usual medical practitioner" would not generally apply to a practice that provides only one specific CDM service.

A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist with items 229, 230 and 233 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the medical practitioner must meet all regulatory requirements, review and confirm all assessments and see the patient.

Patients being managed under the chronic disease management items may be eligible for:

- individual allied health services (items 10950 to 10970); and/or
- group allied health services (items 81100 to 81125).

More information on eligibility requirements can be found in the explanatory note for individual allied health services and group allied health services.

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

AN.7.18 Medical Practitioner Medication Management Reviews (Items 245 and 249)

Item 245 - Domiciliary Medication Management Review

A Domiciliary Medication Management Review (DMMR) (Item 245), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's medical practitioner and preferred community pharmacy or accredited pharmacist.

Patient eligibility

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review:

- patients for whom quality use of medicines may be an issue or;
- patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

DMMR's are targeted at patients who are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- have had significant changes made to medication treatment regimen in the last three months;
- taking medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- experiencing symptoms suggestive of an adverse drug reaction;
- displaying sub-optimal response to treatment with medicines;
- suspected of non-compliance or inability to manage medication related therapeutic devices;
- having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- attending a number of different doctors, both medical practitioners and specialists; and/or
- recently discharged from a facility / hospital (in the last four weeks).

In referring a patient for a DMMR, medical practitioners should note that only patients meeting the following criteria will have the pharmacist portion funded through a Community Pharmacy Agreement program:

- Is a Medicare and/or Department of Veterans' Affairs (DVA) cardholder or a person who is eligible for a Medicare card;
- Is subject to a chronic condition and/or complex medication regimen; and
- Is failing to respond to treatment in the expected manner.

If the patient does not meet these criteria, the medical practitioner can still issue a referral under this item. However, the remainder of the service will be on a "user pays" basis as determined by the accredited pharmacist.

REGULATORY REQUIREMENTS

In conducting a DMMR, a medical practitioner must, with the patient's consent:

(a) assess a patient is subject to a chronic medical condition and/or complex medication regimen but their therapeutic goals are not being met; and

(b) following that assessment, refer the patient to a community pharmacy or an accredited pharmacist for a DMMR and provide the relevant clinical information required for the review; and

(c) discuss with the reviewing pharmacist the result of that review including suggested medication management strategies; and

(d) develop a written medication management plan following discussion with the patient; and

(e) provide the written medication management plan to a community pharmacy chosen by the patient.

For any particular patient - applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR.

Claiming

A DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The benefit is not claimable until all the components of the item have been rendered.

Benefits for a DMMR service under item 245 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

Provision of a subsequent DMMR must not be made solely by reaching an anniversary date, and the service is not intended to be undertaken on an ongoing review cycle.

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review, only item 245 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 245 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

FURTHER GUIDANCE

A DMMR should generally be undertaken by the patient's usual medical practitioner. This is the medical practitioner, or a medical practitioner working in the same medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of referral to a community pharmacy or an accredited pharmacist includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless exceptional circumstances apply or they are an Aboriginal or Torres Strait Islander patient), what

information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

- Provision to the patient's preferred community pharmacy or accredited pharmacist, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.

A DMMR referral form is available for this purpose. If this form is not used, the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy or accredited pharmacist.

The discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist includes:

- Receiving a written report from the reviewing pharmacist; and
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and
- Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of a written medication management plan following discussion with the patient includes:

- Developing a draft medication management plan and discussing this with the patient; and

- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacy or accredited pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

Item 249 - Residential Medication Management Review

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

Patient eligibility

RMMRs are available to:

- new residents on admission into a RACF; and
- existing residents on an 'as required' basis, where in the opinion of the resident's medical practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

REGULATORY REQUIREMENTS

When conducting a RMMR, a medical practitioner must:

(a) discuss the proposed review with the resident and seek the resident's consent to the review; and

(b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and

(c) provide input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, provide relevant clinical information for the review and for the resident's records; and

(d) If recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:

(i) the findings; and

(ii) medication management strategies; and

(iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and

(iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and

(v) finalise the plan after discussion with the resident.

A medical practitioner's involvement in a residential medication management review also includes:

(a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and

(b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

(a) there are no recommended changes to the resident's medication management arising out of the review; or

(b) any changes are minor in nature and do not require immediate discussion; or

(c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.

A RMMR comprises all activities to be undertaken by the medical practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

Claiming

A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Benefits are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

- any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;
- any subsequent follow up should be treated as a separate consultation item;
- an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the medical practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the

circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

FURTHER GUIDANCE

A RMMR should generally be undertaken by the resident's 'usual medical practitioner'. This is the medical practitioner, or a medical practitioner working in the same medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

Medical practitioners who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable time-frame. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's medical practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

The medical practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The medical practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

AN.7.19 Medical Practitioner Cervical Screen from a Person Who is Unscreened or Significantly Under-Screened (Items 251 to 257)

Eligibility

Items 251 to 257 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A19, Subgroup 1.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

Item numbers 251, 252, 253, 254, 255, 256 and 257 should be used in place of the usual attendance item where as part of a consultation, a sample for cervical screening is collected from a person between the ages of 24 years and 9 months and 74 years inclusive who has not had a cervical smear in the last four years. Cervical Screening in accordance with the National Cervical Screening Policy at P.16.11.

Self-collection of a sample for screening is only available for women between the ages of 30 and 74 years of age who are overdue for screening by two or more years (i.e. being 4 years since their last Pap test). Self-collection should only be offered to an eligible person who refuses to have a sample collected by their requesting practitioner.

When providing this service, the medical practitioner must satisfy themselves that the person has not had a cervical screening test in the last four years by:

(a) asking the person if they can remember having a cervical screening test in the last four years;

(b) checking their own practice's medical records; and

(c) checking the National Cancer Screening Register.

A person from the following groups are more likely than the general population to be unscreened or significantly under screened - low socio-economic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older people.

Vault smears are not eligible for items 251 to 257.

In addition to attracting a Medicare rebate, the use of these items will initiate a Cervical Screening SIP through the PIP.

A PIP Cervical Screening SIP is available for taking a cervical screen from a person who has not been screened in the last for four years. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a medical practice participating in the PIP Cervical Screening Incentive. A further PIP Cervical Screening Incentive payment is paid to medical practices which reach target levels of cervical screening for their patients aged 24 years and 9 months of age to 74 years inclusive. More detailed information on the PIP Cervical Screening Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or from the Department of Human Services website.

AN.7.20 Medical Practitioner Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus (Items 259 to 264)

Eligibility

Items 259 to 264 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A19, Subgroup 2.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

Item numbers 259, 260, 261, 262, 263 and 264 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the annual Diabetes Cycle of Care for a patient with established diabetes mellitus.

The annual Diabetes Cycle of Care must be completed over a period of 11 months and up to 13 months, and at a minimum must include:

Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out*	At least once every two years
Measure weight and height and calculate BMI**	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet***	At least twice every cycle of care
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Test for estimated Glomerular Filtration Rate (eGFR)	At least once every year
Provide self-care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of Medication	Medication review

*Not required if the patient is blind or does not have both eyes.

**Initial visit: measure height and weight and calculate BMI as part of the initial assessment.

Subsequent visits: measure weight.

***Not required if the patient does not have both feet.

These requirements are generally based on the current guidelines produced by Diabetes Australia and the Royal Australian College of General Practitioners (Diabetes Management in General Practice). Medical practitioners using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.

Use of these items certifies that the minimum requirements of the Diabetes Cycle of Care have been completed for a patient with established diabetes mellitus in accordance with the guidelines above.

These items should only be used once per cycle per patient: A7 Subgroup 8, A18 Subgroup 2 or A19 Subgroup 2. For example, if item 259 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same cycle.

The requirements for claiming these items are the minimum needed to provide good care for a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

In addition to attracting a Medicare rebate, recording a completion of a Diabetes Cycle of Care through the use of these items will initiate a Diabetes Service Incentive Payment (SIP) through the Practice Incentives Program (PIP).

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Diabetes Cycle of Care.

A PIP Diabetes SIP is available for completing the minimum requirements of the Diabetes Cycle of Care for individual patients as specified above. The Diabetes SIP is only paid once every 11-13 month period per patient. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a medical practice participating in the PIP Diabetes Incentive. A further PIP Diabetes Incentive payment is paid to medical practices which reach target levels of care for their patients with diabetes mellitus. More detailed information on the PIP Diabetes Incentive is available from the Department of Human Services PIP enquiry line on 1800 222 032 or the Department of Human Services website.

AN.7.21 Medical Practitioner Completion of the Asthma Cycle of Care (Items 265 to 271)

Eligibility

Items 265 to 271 are available to medical practitioners providing services in eligible areas.

Eligible area means an area that is a Modified Monash 2 area, Modified Monash 3 area, Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Medical practitioners providing services in a Modified Monash 1 area should use the items in Group A19, Subgroup 3.

A locator map to identify a medical practice's Modified Monash Model Area location is available at the DoctorConnect website at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

Guidance Notes

Item numbers 265, 266, 268, 269, 270 and 271 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the Asthma Cycle of Care. The Practice Incentives Program (PIP) Asthma Incentive is for patients with moderate to severe asthma who in the opinion of the medical practitioner could benefit from review, eg those whose asthma management could be improved.

At a minimum the Asthma Cycle of Care must include:

- At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation);
- Documented diagnosis and assessment of level of asthma control and severity of asthma;
- Review of the patient's use of and access to asthma-related medication and devices;
- Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan - discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records);
- Provision of asthma self-management education to the patient, and
- Review of the written or documented asthma action plan.

The Asthma Cycle of Care should be provided to a patient by one medical practitioner or in exceptional circumstances by another medical practitioner within the same practice. In most cases, this will be the patient's usual medical practitioner. Completion of the Asthma Cycle of Care does not preclude referral to a specialist, but a specialist consultation cannot be counted as one of the two visits.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient-held written asthma action plan.

These items will only be payable for the completion of one Asthma Cycle of Care for each eligible patient per 12 month period, unless a further Asthma Cycle of Care is clinically indicated by exceptional circumstances.

If a subsequent Asthma Cycle of Care is indicated and the incentive item is to be claimed more than once per 12 month period for a patient, then the patient's invoice or Medicare voucher should be annotated to indicate that the Asthma Cycle of Care was required to be provided within 12 months of another Asthma Cycle of Care.

The minimum requirements of the Asthma Cycle of Care may be carried out in two (2) visits or if necessary as many visits as clinically required. The National Asthma Council's website provides a guide for completion of the Asthma Cycle of Care.

The visit that completes the Asthma Cycle of Care should be billed using the appropriate item listed in Group A7 Subgroup 8.

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma Cycle of Care.

In addition to attracting a Medicare rebate, recording a completion of an Asthma Cycle of Care through the use of these items, will initiate an Asthma Service Incentive Payment (SIP) through the PIP.

A PIP Asthma SIP is available for completing the minimum requirements of the Asthma Cycle of Care for individual patients as specified above. The SIP will be paid to the medical practitioner who provided the service if the service was provided in a medical practice participating in the PIP Asthma Incentive. More detailed information on the PIP Asthma Incentive is available from the Department of Human Services PIP enquiry line on 1800222032 or from the Department of Human Services website.

For more detailed information regarding asthma diagnosis, assessment and best practice management refer to the National Asthma Council's website.

Assessment of Severity

Generally, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

- Symptoms on most days, OR
- Use of preventer medication, OR
- Bronchodilator use at least 3 times per week, OR
- Hospital attendance or admission following an acute exacerbation of asthma.

Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's Asthma Management Handbook can be used. Visit the National Asthma Council's website for more details.

AN.7.22 Medical Practitioner Mental Health Treatment (Items 272 to 282)

This note provides information on the Mental Health Treatment items 272, 276, 277, 279, 281 and 282. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other Medicare items and additional claiming information.

Overview

The Mental Health Treatment items define services for which Medicare rebates are payable where medical practitioners undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health

workers. These items complement the mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80021) and allied mental health providers (items 80100 - 80171).

The Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan;
- provide and/or refer for appropriate treatment and services; and
- review and ongoing management as required.

Who can provide

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by medical practitioners, but excluding specialists or consultant physicians.

Training Requirements (item 281 and 282)

Medical practitioner providing GP Mental Health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 281 and 282. For medical practitioners who have not undertaken training, items 272 and 276 are available. Items 272 provides for a GP Mental Health Treatment Plan lasting at least 20 minutes and item 276 provides for a GP Mental Health Treatment Plan lasting at least 40 minutes. It is strongly recommended that medical practitioners providing mental health treatment have appropriate mental health training. Medical professional organisations support the value of appropriate mental health training for medical practitioners using these items.

Which patients are eligible - Mental Disorder

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the Mental Health Treatment items.

These services are available to eligible patients in the community. Mental Health Treatment Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital. Where the medical practitioner who provides the Mental Health Treatment item is providing in-patient treatment the item is claimed as an in-hospital service (at 75% MBS rebate). Medical practitioners are able to contribute to care plans for patients using item 231, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 232.

PREPARING A GP MENTAL HEALTH TREATMENT PLAN (Item 272, 276, 281 or 282)

What is involved - Assess and Plan

A rebate can be claimed once the medical practitioner has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement).

Assessment

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Treatment Plan service;

- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 272, 276, 281 or 282.

In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Treatment Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner. Medical practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

Preparation of a GP Mental Health Treatment Plan

In addition to assessment of the patient, preparation of a GP Mental Health Treatment Plan must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient - what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained medical practitioner or allied mental health professional for provision of focussed psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare either through items 272, 276, 281 or 282 or through GP items 2700, 2701, 2715 or2717, a patient is eligible to be referred for up to 10 Medicare rebateable allied mental health services per calendar year for psychological therapy or focussed psychological strategy services. Patients will also be eligible to claim up to 10 separate services for the provision of group therapy (either as part of psychological therapy or focussed psychological strategies).

When referring patients medical practitioners should provide similar information as per normal referral arrangements. This could include providing a copy of the patient's GP Mental Health Treatment Plan, where

appropriate and with the patient's agreement. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

On completion of a course of treatment provided through Medicare rebateable services, the service provider must provide a written report on the course of treatment to the medical practitioner. For the purposes of the Medicare rebateable allied mental health items, a course of treatment will consist of the number of services stated on the patient's referral (up to a maximum of six in any one referral). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The number of services that the patient is being referred for is at the discretion of the referring medical practitioner.

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A rebate for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a GP Mental Health Treatment Review (item 277 or GP item 2712).

REVIEWING A GP MENTAL HEALTH TREATMENT PLAN (Item 277)

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

A rebate can be claimed once the medical practitioner who prepared the patient's GP Mental Health Treatment Plan (or another medical practitioner in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP Mental Health Treatment Plan by completing the activities that must be included in a review and meeting the relevant requirements listed under 'Additional Claiming Information'. The review item can also be used where a psychiatrist has prepared a referred assessment and management plan (item 291), as if that patient had a GP Mental Health Treatment Plan. The review service must include a personal attendance by the medical practitioner with the patient.

The review must include:

- recording the patient's agreement for this service;
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;
- modification of the documented GP Mental Health Treatment Plan if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the medical practitioner as part of ongoing management.

The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
- if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A rebate will not be paid within three months of a previous claim for the same item/s or within four weeks following a claim for a GP Mental Health Treatment Plan item.

GP MENTAL HEALTH TREATMENT CONSULTATION (Item 279)

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services as per normal referral arrangements. This does not include referral for Medicare rebateable services for focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the medical practitioner under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291).

Consultations associated with this item must be at least 20 minutes duration.

REFERRAL

Once a GP Mental Health Treatment Plan has been completed and claimed on Medicare, or a medical practitioner is managing a patient under a referred psychiatrist assessment and management plan (item 291), a patient is eligible for up to 10 Medicare rebateable allied mental health services per calendar year for services by:

- clinical psychologists providing psychological therapies; or
- appropriately trained medical practitioners or allied mental health professionals providing focussed psychological strategy (FPS) services.

In addition to the above services, patients will also be eligible to claim up to 10 separate services for the provision of group therapy.

When referring patients, medical practitioners should provide similar information as per normal referral arrangements, and specifically consider including both a statement identifying that a GP Mental Health Treatment Plan has been completed for the patient (including, where appropriate and with the patient's agreement, attaching a copy of the patient's GP Mental Health Treatment Plan) and clearly identifying the specific number of sessions the patient is being referred for. Referrals for patients with either a GP Mental Health Treatment Plan or referred psychiatrist assessment and management plan (item 291) should be provided, as required, for an initial course of treatment (a maximum of six services in any one referral but may be less depending on the referral and the patient's clinical need). There may be two or more courses of treatment within a patient's entitlement of up to 10 services per calendar year. The medical practitioner should consider the patient's clinical need for further sessions after the initial

referral. This can be done using a GP Mental Health Treatment Plan Review, a GP Mental Health Treatment Consultation or a standard consultation item.

In the instance where a patient has received the 10 psychological therapy services (items 80000 to 80021), focussed psychological services-allied mental health services (items 80100 to 80171) or GP focussed psychological strategies services (items 283 to 287 or GP items 2721 to 2727) available under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative per calendar year and is considered to clinically benefit from some additional services, the patient may be eligible for Primary Health Networks (PHNs) funded psychological therapies if they meet relevant eligibility criteria for the PHN commissioned services. It is recommended that providers refer to their PHN for further guidance.

ADDITIONAL CLAIMING INFORMATION

Before proceeding with any GP Mental Health Treatment Plan or Review service the medical practitioner must ensure that:

(a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and

(b) the patient's agreement to proceed is recorded.

Before completing any GP Mental Health Treatment Plan or Review service and claiming a benefit for that service, the medical practitioner must offer the patient a copy of the treatment plan or reviewed treatment plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The medical practitioner may, with the permission of the patient, provide a copy of the GP Mental Health Treatment Plan, or relevant parts of the plan, to other providers involved in the patient's treatment.

The GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;
- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and
- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where separate consultations are undertaken in conjunction with mental health consultations, the patient's invoice or Medicare voucher (assignment of benefit form) for the separate consultation should be annotated (e.g. separate consultation clinically required/indicated).

A benefit is not claimable and an account should not be rendered until all components of the relevant item have been provided.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the medical practitioner and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner, Aboriginal and Torres Strait Islander health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to medical practitioners in provision of mental health care.

Links to other Medicare Services

It is preferable that wherever possible patients have only one plan for primary care management of their mental disorder. As a general principle the creation of multiple plans should be avoided, unless the patient clearly requires an additional plan for the management of a separate medical condition.

The Chronic Disease Management (CDM) care plan items (items 229, 230, 231, 232 and 233, and GP items 721, 723, 729, 731 and 732) continue to be available for patients with chronic medical conditions, including patients with complex needs.

- Where a patient has a mental health condition only, it is anticipated that they will be managed under the GP Mental Health Treatment items.
- Where a patient has a separate chronic medical condition, it may be appropriate to manage the patient's medical condition through a GP Management Plan, and to manage their mental health condition through a GP Mental Health Treatment Plan. In this case, both items can be used.
- Where a patient has a mental health condition as well as significant co-morbidities and complex needs requiring team-based care, the medical practitioner is able to use both the CDM items (for team-based care) and the GP Mental Health Treatment items.

AN.7.23 Medical Practitioner Provision of Focussed Psychological Strategies (Items 283 to 287, 371 and 372)

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a GP Mental Health Treatment Plan, shared care plan or a psychiatrist assessment and management plan.

Minimum Requirements

All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (but not including a specialist or consultant physician).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with the Department of Human Services as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 283 to 287, 371 and 372 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

Patients will be permitted to claim Medicare rebates for up to 10 allied mental health services under these item numbers per calendar year. The 10 services may consist of: GP focussed psychological strategies services (items 283 to 287, 371 and 372 or GP items 2721 to 2731); and/or psychological therapy services (items 80000 to 80015); and/or focussed psychological strategies – allied mental health services (items 80100 to 80115; 80125 to 80140; 80150 to 80165).

Out-of-Surgery Consultation

It is expected that this service would be provided only for patients who are unable to attend the practice.

Telehealth Consultation

A **telehealth area** means an area that is a Modified Monash 4 area, Modified Monash 5 area, Modified Monash 6 area or Modified Monash 7 area.

Specific Modified Monash locations can be looked up at DoctorConnect

Specific Focussed Psychological Strategies

A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education
(including motivational interviewing)
2. Cognitive-behavioural therapy including:
· **Behavioural interventions**
- Behaviour modification
- Exposure techniques
- Activity scheduling
· **Cognitive interventions**
- Cognitive therapy
3. Relaxation strategies
- Progressive muscle relaxation
- Controlled breathing
4. Skills training
- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training
5. Interpersonal therapy

Mental Disorder

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care:ICD - 10 Chapter V Primary Health Care Version.

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

AN.7.24 Medical Practitioner After-Hours Attendances To Which No Other Item Applies (Items 733 to 789)

After-hours attendance items may be claimed as follows:

Items **733, 737, 741 and 745** apply only to a professional attendance on 1 patient on 1 occasion that is provided:

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

Items **761, 763, 766, 769, 772, 776, 788 and 789** apply to a professional attendance on 1 or more patients on 1 occasion that is provided:

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

AN.7.25 Medical Practitioner Non-Directive Pregnancy Support Counselling Service (Item 792)

The Pregnancy Support Counselling initiative provides for Medicare benefits to be paid for non-directive pregnancy support counselling services provided to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy, by an eligible medical practitioner (not including a specialist or consultant physician) or allied health professional on referral from a medical practitioner.

There are five MBS items for the provision of non-directive pregnancy support counselling services:

- Item 792 – services provided by an eligible medical practitioner;
- Item 4001 - services provided by an eligible GP;
- Item 81000 - services provided by an eligible psychologist;
- Item 81005 - services provided by an eligible social worker; and
- Item 81010 - services provided by an eligible mental health nurse.

This note relates to the provision of a non-directive pregnancy support counselling service by an eligible medical practitioner.

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

The service involves the medical practitioner undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

Patient eligibility

Medicare rebates for non-directive pregnancy support counselling services provided using item 792 are available to a person who is pregnant or who has been pregnant in the 12 months preceding the first service to which this item or item 4001, 81000, 81005 or 81010 applies in relation to that pregnancy.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

Medicare benefits

Medicare benefits are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy, from any of the following items – 792, 4001, 81000, 81005 and 81010.

Where the patient is unsure of the number of Medicare rebated non-directive pregnancy support counselling services they have already accessed, the patient may check with the Department of Human Services on 132 011. Alternatively, the medical practitioner may check with the Department of Human Services (although the patient must be present to give permission).

Item 10990 or item 10991 can also be claimed in conjunction with item 792 provided the conditions of the relevant item, 10990 or 10991, are satisfied.

Minimum Requirements

This service may only be provided by a medical practitioner who has completed appropriate non-directive pregnancy counselling training.

AN.7.26 Medical Practitioner Telehealth Patient-End Support Services (Items 812 to 892)

This note provides information on the telehealth MBS attendance items for medical practitioners to provide clinical support to their patients, when clinically relevant, during video consultations with specialists or consultant physicians under items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885 and 892.

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

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

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

Clinical indications

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

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

Collaborative Consultation

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

Restrictions

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

Eligible Geographical Areas

Geographic eligibility for telehealth services funded under Medicare is determined according to the Australian Standard Geographical Classification Remoteness Area (ASGC-RA) classifications. Telehealth Eligible Areas are those areas that are outside a Major City (RA1) according to ASGC-RA (RA2-5). Patients and providers are able to check their eligibility by following the links on the MBS Online website (www.mbsonline.gov.au/telehealth).

There is a requirement for the patient and specialist to be located a minimum of 15km apart at the time of the consultation. Minimum distance between specialist and patient video consultations are measured by the most direct (ie least distance) route by road. The patient or the specialist is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

This rule will not apply to specialist video consultation with patients who are a care recipient in an eligible residential care service; or at an eligible Aboriginal Medical Service or Aboriginal Community Controlled Health Service for which there is a direction, made under subsection 19(2) of the Health Insurance Act 1973, as these patients are able to receive telehealth services anywhere in Australia.

Telehealth Eligible Service Areas are defined at www.mbsonline.gov.au/telehealtheligibleareas

Record Keeping

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

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

Multiple attendances on the same day

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

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

Extended Medicare Safety Net (EMSN)

Items which provide for telehealth patient-end support services are subject to EMSN caps equal to 300% of the schedule fee (to a maximum of $500). This is consistent with Government policy relating to capping EMSN for MBS consultation services.

Aftercare Rule

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

Referrals

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

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the remote practitioner. If the remote practitioner is unable to establish both a video and audio link with the patient, a MBS rebate for a specialist video consultation is not payable.

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

Bulk billing

Bulk bill incentive items 10990 or 10991 may be billed in conjunction with the telehealth items 812, 827, 829, 867, 868, 869, 873, 876, 881, 885 and 892.

Duration of attendance

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

AN.7.27 Non-Specialist Practitioner Multidisciplinary Case Conferences (Items 235 to 244)

Items 235 to 244 provide rebates for medical practitioners to organise and coordinate, or participate in, multidisciplinary case conferences for patients in the community or patients being discharged into the community from hospital or people living in residential aged care facilities. This group of items include two items for medical practitioners participating in cancer care case conferences.

REGULATORY REQUIREMENTS

To organise and coordinate case conference items 235, 236 and 237, the medical practitioner must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient for their agreement to the conference taking place; and

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

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

(d) record the names of the participants; and

(e) offer the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a summary of the conference and provide this summary to other team members; and

(f) discuss the outcomes of the conference with the patient and the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees); and

(g) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

To participate in multidisciplinary case conference items 238, 239 and 240, the medical practitioner must:

(a) explain to the patient the nature of a multidisciplinary case conference, and ask the patient whether they agree to the medical practitioner's participation in the conference; and

(b) record the patient's agreement to the medical practitioner's participation; and

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

(d) record the names of the participants; and

(e) record all matters discussed and identified by the case conferencing team and put a copy of that record in the patient's medical records.

Cancer care case conference items 243 and 244

For the purposes of these items:

- private patients in public or private hospitals or the community with a malignancy of a solid organ or tissue or a systemic cancer such as a leukaemia or lymphoma are covered, with the exception of patients whose only cancer is a non-melanoma skin cancer;

- the billing medical practitioner must be a treating doctor of the patient discussed at the case conference. A treating doctor should generally have treated or provided a formal diagnosis of the patient's cancer in the past 12 months or expect to do so within the next 12 months. Attending non-treating clinicians, allied health providers or support staff are not eligible to bill the item;

- only one medical practitioner is eligible to claim item 243 for each patient case conference. This should be the medical practitioner who assumes responsibility for leading and coordinating the case conference, ensures that records are kept and that the patient is informed of the outcome of the case conference. In most cases this will be the lead treating medical practitioner;

- each billing medical practitioner must ensure that his or her patient is informed that a charge will be incurred for the case conference for which a Medicare rebate will be payable;

- participants must be in communication with each other throughout the case conference, either face-to-face, or by telephone or video link;

- suitable allied health practitioners would generally be from one of the following disciplines: aboriginal health care worker; asthma educator; audiologist; dental therapist; dentist; diabetes educator; dietitian; mental health worker; occupational therapist; optometrist; orthoptist; orthotist or prosthetist; pharmacist; physiotherapist; podiatrist; psychologist; registered nurse; social worker; or speech pathologist;

- in general, it is expected that no more than two case conferences per patient per year will be billed by a medical practitioner; and

- cancer care case conferences are for the purpose of developing a cancer treatment plan in a multidisciplinary team meeting and should not be billed against case conference items for other purposes (eg. community or discharge case conferences).

ADDITIONAL INFORMATION

Usual medical practitioner

Items 235 to 244 should generally be undertaken by the patient's usual medical practitioner. This is a medical practitioner, or a medical practitioner working in the same medical practice that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

Multidisciplinary case conference team members

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dietitians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Discharge case conference

Organisation and coordination of a multidisciplinary discharge case conference (items 235, 236 and 237) may be provided for private in-patients being discharged into the community from hospital.

Further sources of information

Advice on the items and further guidance are available at: www.health.gov.au/mbsprimarycareitems

Further information is also available for providers from the Department of Human Services provider inquiry line on 132 150.

AN.30.1 MBS mental health and well-being telehealth support items for general practitioners

These notes provide information on the MBS mental health and well-being telehealth support items for general practitioners (GPs) under items 2121, 2150 and 2196 in Group A30, Subgroup 3.

Requirements

The mental health and well-being telehealth support items can only be claimed where:

a. the patient lives in an area belonging to a declared council under the Drought Communities Programme (DCP);

a. the GP works in an area belonging to the declared councils under the DCP, or in a Modified Monash area 3 to 7; and

- the patient and the GP have an existing relationship.

A list of declared councils and more information about the Drought Communities Programme is available at: http://regional.gov.au/regional/programs/drought-communities.aspx

Information about Modified Monash is available at http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/locator

In addition:

- the attendance must be by video conference; and
- the patient must not be an admitted patient; and
- the patient must be, at the time of the attendance, at least 15 kilometres by road from the GP.

Minimum Distance

The minimum distance between the GP and the patient is measured by the most direct (ie least distance) route by road. The patient or the GP is not permitted to travel to an area outside the minimum 15 km distance in order to claim a video conference.

Record Keeping

Participating GPs must keep contemporaneous notes of the consultation including documenting that the service was performed by video conference, the date and the time.

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

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

Medicare benefits may be paid for more than one video consultation on a patient on the same day by the GP, provided the second (and any following) video consultations are not a continuation of the initial or earlier video

consultations. GPs will need to provide the times of each consultation on the patient's account or bulk billing voucher.

Extended Medicare Safety Net (EMSN)

Items which provide for telehealth patient-end support services are subject to EMSN caps equal to 300% of the schedule fee (to a maximum of $500). This is consistent with Government policy relating to capping EMSN for MBS consultation services.

Aftercare Rule

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

Technical requirements

In order to fulfil the item descriptor there must be a visual and audio link between the patient and the GP. If the GP is unable to establish both a video and audio link with the patient, a MBS rebate for a video consultation is not payable.

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

AN.33.1 TAVI CASE CONFERENCE - (ITEMS 6080 AND 6081)

Items 6080 and 6081 apply to a TAVI Case Conference organised to discuss a patient's suitability to receive the service described in Item 38495 for Transcatheter Aortic Valve Implantation (TAVI).

For items 6080 and 6081 a TAVI Case Conference is a process by which:

(a) there is a team of 3 or more participants, where:

(i) the first participant is a cardiothoracic surgeon; and

(ii) the second participant is an interventional cardiologist; and

(iii) the third participant is a specialist or consultant physician who does not perform a service described in Item 38495 for the patient being assessed; and

(iv) either the first or the second participant is also a TAVI Practitioner; and

(b) the team assesses a patient's risk and technical suitability to receive the service described in Item 38495, taking into account matters such as:

(i) the patient's risk and technical suitability for a surgical aortic valve replacement; and

(ii) the patient's cognitive function and frailty; and

(c) the result of the assessment is that the team makes a recommendation about whether or not the patient is suitable to receive the service described in Item 38495; and

(d) the particulars of the assessment and recommendation are recorded in writing.

TAVI Practitioner

For items 6080 and 6081 a TAVI Practitioner is either a cardiothoracic surgeon or interventional cardiologist who is accredited by Cardiac Accreditation Services Limited.

Accreditation by Cardiac Accreditation Services Limited must be valid prior to the service being undertaken in order for benefits to be payable under item 38495.

The process for accreditation and re-accreditation is outlined in the *Transcatheter Aortic Valve Implantation - Rules for the Accreditation of TAVI Practitioners*, issued by Cardiac Accreditation Services Limited, and is available on the Cardiac Accreditation Services Limited website, www.tavi.org.au.

Cardiac Accreditation Services Limited is a national body comprising representatives from the Australian & New Zealand Society of Cardiac & Thoracic Surgeons (ANZSCTS) and the Cardiac Society of Australia and New Zealand (CSANZ).

Coordination of a TAVI Case Conference

For item 6080, coordination means undertaking all of the following activities in relation to a TAVI Case Conference:

a. ensuring that the patient is aware of the purpose and nature of the patient's TAVI Case Conference and has consented to their TAVI Case Conference;
b. recording the day the conference was held, and the times the conference started and ended;
c. recording the names of the participants of the conference;
d. provision of expertise to inform the recommendation resulting from the case conference;
e. recording minutes of the TAVI Case Conference including the recommendation resulting from the conference;
f. ensuring that the patient is aware of the recommendation.

Attendance at a TAVI Case Conference

For item 6081, attendance means undertaking all of the following activities in relation to a TAVI Case Conference:

a. retaining a record of the day the conference was held, and the times the conference started and ended;
b. retaining a record of the names of the participants;
c. provision of expertise to inform the recommendation resulting from the case conference;
d. retaining a record of the recommendation resulting from the conference.

General requirements

The TAVI Case Conference must be arranged in advance, within a time frame that allows for all the participants to attend. A TAVI Case Conference is to last at least 10 minutes and a minimum of three suitable participants (as defined under the item requirements), must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A record of the TAVI Case Conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the assessment of suitability; and a summary of the outcomes must be kept in the patient's record. The notes and summary of outcomes must be provided to all participants.

Prior informed consent must be obtained from the patient, or the patient's agent. In obtaining informed consent the TAVI Practitioner coordinating the TAVI Case Conference should ensure the patient has been:

- Informed that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;
- Informed that he or she may incur a charge for the service for which a Medicare rebate will be payable.

Medicare benefits are only payable in respect of the service provided by the coordinating TAVI Practitioner or the attending interventional cardiologist, cardiothoracic surgeon or independent specialist or consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for attendance by other medical practitioners at a TAVI Case Conference.

It is expected that a patient would not normally require more than one TAVI Case Conference in determining suitability for the services described in Item 38495. As such, item 6080 is only payable once per patient in a five year period. Item 6081 is payable only twice per patient in a five year period.

Items 6080 and 6081 do not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

AN.34.1 HEALTH CARE HOMES

HEALTH CARE HOMES The Health Care Homes Program is administered by the Department of Health. A Health Care Homes trial site means a medical practice participating in the Health Care Homes Program. Commonwealth subsidy for the provision of services under the Health Care Homes Program is paid through bundled payments to the Health Care Home.

Item 6087 has been established so that, when claimed, it will record when a Health Care Home patient incurs an out-of-pocket expense. The out-of-pocket cost will then count toward their or their family's Extended Medicare Safety Net.

Item 6087 should only be claimed in the event that a Health Care Home charges a Health Care Home patient an out-of-pocket cost. Item 6087 must not be used for any other purpose.

Item 6087 cannot be claimed as a bulk-billed service.

1. FEES AND BENEFITS FOR GP ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A - ITEM 20		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	64.60	64.60
TWO	40.90	40.90
THREE	33.00	33.00
FOUR	29.05	29.05
FIVE	26.70	26.70
SIX	25.10	25.10
SEVEN	20.55	20.55

LEVEL B - ITEM 35		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	85.00	85.00
TWO	61.30	61.30
THREE	53.40	53.40
FOUR	49.45	49.45
FIVE	47.10	47.10
SIX	45.50	45.50
SEVEN	40.95	40.95

LEVEL C - ITEM 43		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	120.20	120.20
TWO	96.50	96.50
THREE	88.60	88.60
FOUR	84.65	84.65
FIVE	82.30	82.30
SIX	80.70	80.70
SEVEN	76.15	76.15

LEVEL D - ITEM 51		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	154.55	154.55
TWO	130.85	130.85
THREE	122.95	122.95
FOUR	119.00	119.00
FIVE	116.65	116.65
SIX	115.05	115.05
SEVEN	110.50	110.50

2. FEES AND BENEFITS FOR OTHER NON-REFERRED ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

BRIEF - ITEM 92		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	36.45	36.45
TWO	22.45	22.45
THREE	17.80	17.80
FOUR	15.50	15.50
FIVE	14.10	14.10
SIX	13.15	13.15
SEVEN	9.75	9.75

STANDARD - ITEM 93		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	47.55	47.55
TWO	31.75	31.75
THREE	26.50	26.50
FOUR	23.90	23.90
FIVE	22.30	22.30
SIX	21.25	21.25
SEVEN	17.25	17.25

LONG - ITEM 95		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	63.45	63.45
TWO	49.45	49.45
THREE	44.80	44.80
FOUR	42.50	42.50
FIVE	41.10	41.10
SIX	40.15	40.15
SEVEN	36.75	36.75

PROLONGED - ITEM 96		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	85.45	85.45
TWO	71.45	71.45
THREE	66.80	66.80
FOUR	64.50	64.50
FIVE	63.10	63.10
SIX	62.15	62.15
SEVEN	58.75	58.75

AFTER HOURS ATTENDANCES

3. FEES AND BENEFITS FOR GP ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A - ITEM 5010		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	75.70	75.70
TWO	52.35	52.35
THREE	44.55	44.55
FOUR	40.65	40.65
FIVE	38.35	38.35
SIX	36.80	36.80
SEVEN	32.30	32.30

LEVEL B - ITEM 5028		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	95.70	95.70
TWO	72.35	72.35
THREE	64.55	64.55
FOUR	60.65	60.65
FIVE	58.35	58.35
SIX	56.80	56.80
SEVEN	52.30	52.30

LEVEL C - ITEM 5049		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	130.65	130.65
TWO	107.30	107.30
THREE	99.50	99.50
FOUR	95.60	95.60
FIVE	93.30	93.30
SIX	91.75	91.75
SEVEN	87.25	87.25

LEVEL D - ITEM 5067		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	164.45	164.45
TWO	141.10	141.10
THREE	133.30	133.30
FOUR	129.40	129.40
FIVE	127.10	127.10
SIX	125.55	125.55
SEVEN	121.05	121.05

4. FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

BRIEF - ITEM 5260		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	46.45	46.45
TWO	32.45	32.45
THREE	27.80	27.80
FOUR	25.50	25.50
FIVE	24.10	24.10
SIX	23.15	23.15
SEVEN	19.75	19.75

STANDARD - ITEM 5263		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	57.55	57.55
TWO	41.75	41.75
THREE	36.50	36.50
FOUR	33.90	33.90
FIVE	32.30	32.30
SIX	31.25	31.25
SEVEN	27.25	27.25

LONG - ITEM 5265		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	73.45	73.45
TWO	59.45	59.45
THREE	54.80	54.80
FOUR	52.50	52.50
FIVE	51.10	51.10
SIX	50.15	50.15
SEVEN	46.75	46.75

PROLONGED - ITEM 5267		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	95.45	95.45
TWO	81.45	81.45
THREE	76.80	76.80
FOUR	74.50	74.50
FIVE	73.10	73.10
SIX	72.15	72.15
SEVEN	68.75	68.75

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

LEVEL A - ITEM 4		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	43.55	32.70
TWO	30.35	22.80
THREE	26.00	19.50
FOUR	23.80	17.85
FIVE	22.45	16.85
SIX	21.60	16.20
SEVEN	19.25	14.45

LEVEL B - ITEM 24		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	63.95	48.00
TWO	50.75	38.10
THREE	46.40	34.80
FOUR	44.20	33.15
FIVE	42.85	32.15
SIX	42.00	31.50
SEVEN	39.65	29.75

LEVEL B - ITEM 2503, 2518, 2547		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	63.00	47.25
TWO	50.00	37.50
THREE	45.70	34.30
FOUR	43.55	32.70
FIVE	42.25	31.70
SIX	41.35	31.05
SEVEN	39.05	29.30

LEVEL C – ITEM 37		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	99.15	74.40
TWO	85.95	64.50
THREE	81.60	61.20
FOUR	79.40	59.55
FIVE	78.05	58.55
SIX	77.20	57.90
SEVEN	74.85	56.15

LEVEL C – ITEM 2506, 2522, 2553		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	97.65	73.25
TWO	84.65	63.50
THREE	80.35	60.30
FOUR	78.20	58.65
FIVE	76.90	57.70
SIX	76.00	57.00
SEVEN	73.70	55.30

LEVEL D – ITEM 47		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	133.50	100.15
TWO	120.30	90.25
THREE	115.95	87.00
FOUR	113.75	85.35
FIVE	112.40	84.30
SIX	111.55	83.70
SEVEN	109.20	81.90

LEVEL D – ITEM 2509, 2526, 2559		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	131.50	98.65
TWO	118.50	88.90
THREE	114.20	85.65
FOUR	112.05	84.05
FIVE	110.75	83.10
SIX	109.85	82.40
SEVEN	107.55	80.70

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

BRIEF – ITEM 58		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	24.00	18.00
TWO	16.25	12.20
THREE	13.65	10.25
FOUR	12.35	9.30
FIVE	11.60	8.70
SIX	11.10	8.35
SEVEN	9.20	6.90

STANDARD - ITEM 59, 2610, 2631, 2673		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	33.50	25.15
TWO	24.75	18.60
THREE	21.85	16.40
FOUR	20.35	15.30
FIVE	19.50	14.65
SIX	18.90	14.20
SEVEN	16.70	12.55

LONG – ITEM 60, 2613, 2633, 2675		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	51.00	38.25
TWO	43.25	32.45
THREE	40.65	30.50
FOUR	39.35	29.55
FIVE	38.60	28.95
SIX	38.10	28.60
SEVEN	36.20	27.15

PROLONGED – ITEM 65, 2616, 2635, 2677		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	73.00	54.75
TWO	65.25	48.95
THREE	62.65	47.00
FOUR	61.35	46.05
FIVE	60.60	45.45
SIX	60.10	45.10
SEVEN	58.20	43.65

AFTER HOURS ATTENDANCES

7. FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT AN INSTITUTION OR HOME

LEVEL A – ITEM 5003		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	54.95	54.95
TWO	41.95	41.95
THREE	37.65	37.65
FOUR	35.50	35.50
FIVE	34.20	34.20
SIX	33.30	33.30
SEVEN	31.00	31.00

LEVEL B – ITEM 5023		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	74.95	74.95
TWO	61.95	61.95
THREE	57.65	57.65
FOUR	55.50	55.50
FIVE	54.20	54.20
SIX	53.30	53.30
SEVEN	51.00	51.00

LEVEL C – ITEM 5043		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	109.90	109.90
TWO	96.90	96.90
THREE	92.60	92.60
FOUR	90.45	90.45
FIVE	89.15	89.15
SIX	88.25	88.25
SEVEN	85.95	85.95

LEVEL D – ITEM 5063		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	143.70	143.70
TWO	130.70	130.70
THREE	126.40	126.40
FOUR	124.25	124.25
FIVE	122.95	122.95
SIX	122.05	122.05
SEVEN	119.75	119.75

8. FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT AN INSTITUTION OR HOME

BRIEF – ITEM 5220		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	34.00	34.00
TWO	26.25	26.25
THREE	23.65	23.65
FOUR	22.35	22.35
FIVE	21.60	21.60
SIX	21.10	21.10
SEVEN	19.20	19.20

STANDARD – ITEM 5223		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	43.50	43.50
TWO	34.75	34.75
THREE	31.85	31.85
FOUR	30.35	30.35
FIVE	29.50	29.50
SIX	28.90	28.90
SEVEN	26.70	26.70

LONG – ITEM 5227		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	61.00	61.00
TWO	53.25	53.25
THREE	50.65	50.65
FOUR	49.35	49.35
FIVE	48.60	48.60
SIX	48.10	48.10
SEVEN	46.20	46.20

PROLONGED – ITEM 5228		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	83.00	83.00
TWO	75.25	75.25
THREE	72.65	72.65
FOUR	71.35	71.35
FIVE	70.60	70.60
SIX	70.10	70.10
SEVEN	68.20	68.20

9. PUBLIC HEALTH PHYSICIAN ATTENDANCES

ITEM 414		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	45.70	34.30
TWO	32.75	24.60
THREE	28.45	21.35
FOUR	26.30	19.75
FIVE	25.00	18.75
SIX	24.15	18.15
SEVEN	21.85	16.40

ITEM 415		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	69.25	51.95
TWO	56.30	42.25
THREE	52.00	39.00
FOUR	49.85	37.40
FIVE	48.55	36.45
SIX	47.70	35.80
SEVEN	45.40	34.05

ITEM 416		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	109.75	82.35
TWO	96.80	72.60
THREE	92.50	69.40
FOUR	90.35	67.80
FIVE	89.05	66.80
SIX	88.20	66.15
SEVEN	85.90	64.45

ITEM 417		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**75% BENEFIT (PER PATIENT)**
ONE	149.40	112.05
TWO	136.45	102.35
THREE	132.15	99.15
FOUR	130.00	97.50
FIVE	128.70	96.55
SIX	127.85	95.90
SEVEN	125.55	94.20

10. FOCUSSED PSYCHOLOGICAL STRATEGIES

ITEM 2723		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	118.70	118.70
TWO	105.70	105.70
THREE	101.40	101.40
FOUR	99.25	99.25
FIVE	97.95	97.95
SIX	97.05	97.05
SEVEN	94.75	94.75

ITEM 2727		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	158.70	158.70
TWO	145.70	145.70
THREE	141.40	141.40
FOUR	139.25	139.25
FIVE	137.95	137.95
SIX	137.05	137.05
SEVEN	134.75	134.75

TELEHEALTH DERIVED FEES

11. FEES AND BENEFITS FOR MEDICAL PRACTITIONER TELEHEALTH ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A HOME OR OTHER INSTITUTION

LEVEL A – ITEM 2122		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	48.85	48.85
TWO	35.85	35.85
THREE	31.55	31.55
FOUR	29.40	29.40
FIVE	28.10	28.10
SIX	27.20	27.20
SEVEN	24.90	24.90

LEVEL B – ITEM 2137		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	75.90	75.90
TWO	62.90	62.90
THREE	58.60	58.60
FOUR	56.45	56.45
FIVE	55.15	55.15
SIX	54.25	54.25
SEVEN	51.95	51.95

LEVEL C – ITEM 2147		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	122.80	122.80
TWO	109.80	109.80
THREE	105.50	105.50
FOUR	103.35	103.35
FIVE	102.05	102.05
SIX	101.15	101.15
SEVEN	98.85	98.85

LEVEL D – ITEM 2199		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	168.45	168.45
TWO	155.45	155.45
THREE	151.15	151.15
FOUR	149.00	149.00
FIVE	147.70	147.70
SIX	146.80	146.80
SEVEN	144.50	144.50

12. FEES AND BENEFITS FOR MEDICAL PRACTITIONER TELEHEALTH ATTENDANCES AT A RESIDENTIAL AGED CARE FACILITY

LEVEL A – ITEM 2125		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	69.60	69.60
TWO	46.25	46.25
THREE	38.45	38.45
FOUR	34.55	34.55
FIVE	32.25	32.25
SIX	30.70	30.70
SEVEN	26.20	26.20

LEVEL B – ITEM 2138		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	96.65	96.65
TWO	73.30	73.30
THREE	65.50	65.50
FOUR	61.60	61.60
FIVE	59.30	59.30
SIX	57.75	57.75
SEVEN	53.25	53.25

LEVEL C – ITEM 2179		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	143.55	143.55
TWO	120.20	120.20
THREE	112.40	112.40
FOUR	108.50	108.50
FIVE	106.20	106.20
SIX	104.65	104.65
SEVEN	100.15	100.15

LEVEL D – ITEM 2220		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	189.20	189.20
TWO	165.85	165.85
THREE	158.05	158.05
FOUR	154.15	154.15
FIVE	151.85	151.85
SIX	150.30	150.30
SEVEN	145.80	145.80

13. ACUPUNCTURE

LEVEL A – ITEM 195		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	63.00	63.00
TWO	50.00	50.00
THREE	45.70	45.70
FOUR	43.55	43.55
FIVE	42.25	42.25
SIX	41.35	41.35
SEVEN	39.05	39.05

14. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

ITEM 181		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	34.85	34.85
TWO	24.30	24.30
THREE	20.80	20.80
FOUR	19.00	19.00
FIVE	17.95	17.95
SIX	17.25	17.25
SEVEN	15.40	15.40

ITEM 183		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	51.65	51.65
TWO	32.70	32.70
THREE	26.40	26.40
FOUR	23.20	23.20
FIVE	21.35	21.35
SIX	20.05	20.05
SEVEN	16.45	16.45

ITEM 187		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	51.20	51.20
TWO	40.65	40.65
THREE	37.15	37.15
FOUR	35.35	35.35
FIVE	34.30	34.30
SIX	33.60	33.60
SEVEN	31.75	31.75

ITEM 188		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	68.00	68.00
TWO	49.05	49.05
THREE	42.75	42.75
FOUR	39.55	39.55
FIVE	37.70	37.70
SIX	36.40	36.40
SEVEN	32.80	32.80

ITEM 191		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	79.35	79.35
TWO	68.80	68.80
THREE	65.30	65.30
FOUR	63.50	63.50
FIVE	62.45	62.45
SIX	61.75	61.75
SEVEN	59.90	59.90

ITEM 202		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	96.15	96.15
TWO	77.20	77.20
THREE	70.90	70.90
FOUR	67.70	67.70
FIVE	65.85	65.85
SIX	64.55	64.55
SEVEN	60.95	60.95

ITEM 206		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	106.80	106.80
TWO	96.25	96.25
THREE	92.75	92.75
FOUR	90.95	90.95
FIVE	89.90	89.90
SIX	89.20	89.20
SEVEN	87.35	87.35

ITEM 212		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	123.60	123.60
TWO	104.65	104.65
THREE	98.35	98.35
FOUR	95.15	95.15
FIVE	93.30	93.30
SIX	92.00	92.00
SEVEN	88.40	88.40

15. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER ATTENDANCES ASSOCIATED WITH PRACTICE INCENTIVE PROGRAM PAYMENTS

ITEM 253, 260, 266		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	50.40	50.40
TWO	40.00	40.00
THREE	36.55	36.55
FOUR	34.85	34.85
FIVE	33.80	33.80
SIX	33.10	33.10
SEVEN	31.25	31.25

ITEM 255, 262, 269		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	78.10	78.10
TWO	67.70	67.70
THREE	64.25	64.25
FOUR	62.55	62.55
FIVE	61.50	61.50
SIX	60.80	60.80
SEVEN	58.95	58.95

ITEM 257, 264, 271		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	105.20	105.20
TWO	94.80	94.80
THREE	91.35	91.35
FOUR	89.65	89.65
FIVE	88.60	88.60
SIX	87.90	87.90
SEVEN	86.05	86.05

16. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER MENTAL HEALTH CARE

ITEM 285		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	94.95	94.95
TWO	84.55	84.55
THREE	81.10	81.10
FOUR	79.40	79.40
FIVE	78.35	78.35
SIX	77.65	77.65
SEVEN	75.80	75.80

ITEM 287		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	126.95	126.95
TWO	116.55	116.55
THREE	113.10	113.10
FOUR	111.40	111.40
FIVE	110.35	110.35
SIX	109.65	109.65
SEVEN	107.80	107.80

17. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

ITEM 761		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	43.95	43.95
TWO	33.55	33.55
THREE	30.10	30.10
FOUR	28.40	28.40
FIVE	27.35	27.35
SIX	26.65	26.65
SEVEN	24.80	24.80

ITEM 763		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	59.95	59.95
TWO	49.55	49.55
THREE	46.10	46.10
FOUR	44.40	44.40
FIVE	43.35	43.35
SIX	42.65	42.65
SEVEN	40.80	40.80

ITEM 766		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	87.90	87.90
TWO	77.50	77.50
THREE	74.05	74.05
FOUR	72.35	72.35
FIVE	71.30	71.30
SIX	70.60	70.60
SEVEN	68.75	68.75

ITEM 769		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	114.95	114.95
TWO	104.55	104.55
THREE	101.10	101.10
FOUR	99.40	99.40
FIVE	98.35	98.35
SIX	97.65	97.65
SEVEN	95.80	95.80

ITEM 772		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	60.55	60.55
TWO	41.85	41.85
THREE	35.65	35.65
FOUR	32.55	32.55
FIVE	30.65	30.65
SIX	29.40	29.40
SEVEN	25.85	25.85

ITEM 776		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	76.55	76.55
TWO	57.85	57.85
THREE	51.65	51.65
FOUR	48.55	48.55
FIVE	46.65	46.65
SIX	45.40	45.40
SEVEN	41.85	41.85

ITEM 788		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	104.50	104.50
TWO	85.80	85.80
THREE	79.60	79.60
FOUR	76.50	76.50
FIVE	74.60	74.60
SIX	73.35	73.35
SEVEN	69.80	69.80

ITEM 789		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	131.55	131.55
TWO	112.85	112.85
THREE	106.65	106.65
FOUR	103.55	103.55
FIVE	101.65	101.65
SIX	100.40	100.40
SEVEN	96.85	96.85

18. FEES AND BENEFITS FOR NON-SPECIALIST PRACTITIONER VIDEO CONFERENCING CONSULTATION

ITEM 827		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	39.05	39.05
TWO	28.65	28.65
THREE	25.20	25.20
FOUR	23.50	23.50
FIVE	22.45	22.45
SIX	21.75	21.75
SEVEN	19.90	19.90

ITEM 829		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	55.65	55.65
TWO	36.95	36.95
THREE	30.75	30.75
FOUR	27.65	27.65
FIVE	25.75	25.75
SIX	24.50	24.50
SEVEN	20.95	20.95

ITEM 868		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	60.70	60.70
TWO	50.30	50.30
THREE	46.85	46.85
FOUR	45.15	45.15
FIVE	44.10	44.10
SIX	43.40	43.40
SEVEN	41.55	41.55

ITEM 869		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	77.30	77.30
TWO	58.60	58.60
THREE	52.40	52.40
FOUR	49.30	49.30
FIVE	47.40	47.40
SIX	46.15	46.15
SEVEN	42.60	42.60

ITEM 876		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	98.25	98.25
TWO	87.85	87.85
THREE	84.40	84.40
FOUR	82.70	82.70
FIVE	81.65	81.65
SIX	80.95	80.95
SEVEN	79.10	79.10

ITEM 881		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	114.85	114.85
TWO	96.15	96.15
THREE	89.95	89.95
FOUR	86.85	86.85
FIVE	84.95	84.95
SIX	83.70	83.70
SEVEN	80.15	80.15

ITEM 891		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	134.75	134.75
TWO	124.35	124.35
THREE	120.90	120.90
FOUR	119.20	119.20
FIVE	118.15	118.15
SIX	117.45	117.45
SEVEN	115.60	115.60

ITEM 892		
NUMBER OF PATIENTS	**FEE (PER PATIENT)**	**100% BENEFIT (PER PATIENT)**
ONE	151.35	151.35
TWO	132.65	132.65
THREE	126.45	126.45
FOUR	123.35	123.35
FIVE	121.45	121.45
SIX	120.20	120.20
SEVEN	116.65	116.65

Services that attract the 100% Medicare rebate – as at 1 July 2018

Medicare Benefits Schedule (MBS) Group	Name of Subgroup	Item numbers
Group A1	General practitioner attendances to which no other item applies	3, 4, 20, 23, 24, 35, 36, 37, 43, 44, 47, 51
Group A2	Other non-referred attendances to which no other item applies	52, 53, 54, 57, 58, 59, 60, 65, 92, 93, 95, 96
Group A5	Prolonged attendances to which no other item applies	160, 161, 162, 163, 164
Group A6	Group therapy	170, 171, 172
Group A7	Acupuncture	173, 193, 195, 197, 199
Group A7	Non-Specialist Practitioner attendances to which no other item applies	179, 181, 183, 185, 187, 188, 189, 191, 202, 203, 206, 212
Group A7	Non-Specialist Practitioner prolonged attendances to which no other item applies	214, 215, 218, 219, 220
Group A7	Non-Specialist Practitioner group therapy	221, 222, 223
Group A7	Non-Specialist Practitioner health assessments	224, 225, 226, 227, 228
Group A7	Non-Specialist Practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences	229, 230, 231, 232, 233, 235, 236, 237, 238, 239, 240, 243, 244
Group A7	Non-Specialist Practitioner domiciliary and residential medication management review	245, 249
Group A7	Non-Specialist Practitioner attendances associated with Practice Incentive Program payments	251, 252, 253, 254, 255, 256, 257, 259, 260, 261, 262, 263, 264, 265, 266, 268, 269, 270, 271
Group A7	Non-Specialist Practitioner mental health care	272, 276, 277, 279, 281, 282, 283, 285, 286, 287
Group A7	Non-Specialist Practitioner after-hours attendances to which no other item applies	733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789
Group A7	Non-Specialist Practitioner pregnancy support counselling	792
Group A7	Non-Specialist Practitioner video conferencing consultation	812, 827, 829, 867, 868, 869, 873, 876, 881, 885, 891, 892
Group A11	Urgent Attendances After hours	585, 588, 591, 594, 599, 600
Group A14	Health assessments	701, 703, 705, 707, 715
Group A15	GP care plans and multidisciplinary case conferences	721, 723, 729, 731, 732, 735, 739, 743, 747, 750, 758

Group A17	Medication management review	900, 903
Group A18	General practitioner attendances associated with Practice Incentives Program (PIP) payments	2497, 2501, 2503, 2504, 2506, 2507, 2509, 2517, 2518, 2521, 2522, 2525, 2526, 2546, 2547, 2552, 2553, 2558, 2559,
Group A19	Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies	2598, 2600, 2603, 2606, 2610, 2613, 2616, 2620, 2622, 2624, 2631, 2633, 2635, 2664, 2666, 2668, 2673, 2675, 2677
Group A20	GP mental health care	2700, 2701, 2712, 2713, 2715, 2717, 2721, 2723, 2725, 2727
Group A22	General practitioner after-hours attendances to which no other item applies	5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067
Group A23	Other non-referred after-hours attendances to which no other item applies	5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5260, 5263, 5265, 5267
Group A27	Pregnancy support couselling	4001
Group A29	Early intervention services for children with autism, pervasive developmental disorder or disability	139
Group A30	Medical Practitioners – Telehealth Atendances	2100, 2122, 2125, 2126, 2137, 2138, 2143, 2147, 2179, 2195, 2199, 2220
Group M12	Services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a medical practitioner	10983, 10984, 10987, 10988, 10989, 10997

PROFESSIONAL ATTENDANCES ITEMS

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A1. General Practitioner Attendances To Which No Other Item Applies
	LEVEL A Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
3	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $17.20 **Benefit:** 100% = $17.20 **Extended Medicare Safety Net Cap:** $51.60
4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 3, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
20	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.17, AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 3, plus $47.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $37.60 **Benefit:** 100% = $37.60 **Extended Medicare Safety Net Cap:** $112.80
24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 23, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
35	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 23, plus $47.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $72.80 **Benefit:** 100% = $72.80 **Extended Medicare Safety Net Cap:** $218.40
37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 36, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
43	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 36, plus $47.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
44	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.9 of explanatory notes to this Category) **Fee:** $107.15 **Benefit:** 100% = $107.15 **Extended Medicare Safety Net Cap:** $321.45
47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;

A1. GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.11, AN.0.13, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 44, plus $26.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $2.05 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
51	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 44, plus $47.40 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus $3.35 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	**1. OTHER MEDICAL PRACTITIONER ATTENDANCES**
	Group A2. Other Non-Referred Attendances To Which No Other Item Applies
	Subgroup 1. Other Medical Practitioner Attendances
	CONSULTATION AT CONSULTING ROOMS Professional attendance at consulting rooms
52	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
53	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)-each attendance, by:

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	(a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
54	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
57	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies)-each attendance, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS OR A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms or a residential aged care facility.
58	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Derived Fee:** An amount equal to $8.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
59	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one place on one occasion-each patient,

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
65	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration-an attendance on one or more patients at one place on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion - each patient
92	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of not more than 5 minutes in duration-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies (See para AN.0.17, AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $8.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $8.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
93	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies (See para AN.0.15 of explanatory notes to this Category)

A2. OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. OTHER MEDICAL PRACTITIONER ATTENDANCES
	Derived Fee: An amount equal to $16.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
95	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
96	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self-contained unit) of more than 45 minutes in duration-an attendance on one or more patients at one residential aged care facility on one occasion-each patient, by: (a) a medical practitioner (who is not a general practitioner); or (b) a general practitioner to whom clause 2.3.1 applies (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A3. Specialist Attendances To Which No Other Item Applies
99	Professional attendance on a patient by a specialist practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 104 lasting more than 10 minutes; or (ii) provided with item 105; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both:

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 104 or 105. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
104	Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty 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 106, 109 or 16401 applies (See para TN.1.4 of explanatory notes to this Category) **Fee:** $86.85 **Benefit:** 75% = $65.15 85% = $73.85 **Extended Medicare Safety Net Cap:** $260.55
105	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 (See para TN.1.4, AN.0.70 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
106	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology and following referral of the patient to him or her-an attendance (other than a second or subsequent attendance in a single course of treatment) at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies) **Fee:** $72.05 **Benefit:** 75% = $54.05 85% = $61.25 **Extended Medicare Safety Net Cap:** $216.15
107	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her-an attendance (other than a second or subsequent attendance in a single course of treatment), if that attendance is at a place other than consulting rooms or hospital **Fee:** $127.40 **Benefit:** 75% = $95.55 85% = $108.30 **Extended Medicare Safety Net Cap:** $382.20
108	Professional attendance by a specialist in the practice of his or her specialty following referral of the patient to him or her-each attendance after the first in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital **Fee:** $80.65 **Benefit:** 75% = $60.50 85% = $68.60 **Extended Medicare Safety Net Cap:** $241.95
109	Professional attendance by a specialist in the practice of his or her specialty of ophthalmology following referral of the patient to him or her-an attendance (other than a second or subsequent attendance in a single course of treatment) at which a comprehensive eye examination, including pupil dilation, is

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies) **Fee:** $195.70 **Benefit:** 75% = $146.80 85% = $166.35 **Extended Medicare Safety Net Cap:** $500.00
111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $300 or more For any particular patient, once only on the same day **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
113	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist in the practice of his or her speciality if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) 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; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category)

A3. SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Fee: $65.15 **Benefit:** 85% = $55.40 **Extended Medicare Safety Net Cap:** $195.45
A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A4. Consultant Physician Attendances To Which No Other Item Applies
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20 **Extended Medicare Safety Net Cap:** $459.45
112	Professional attendance on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 110 lasting more than 10 minutes; or (ii) provided with item 116, 119, 132 or 133; 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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
114	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant physician practising in his or her specialty if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient:

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $114.90 **Benefit:** 85% = $97.70 **Extended Medicare Safety Net Cap:** $344.70
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner-each attendance (other than a service to which item 119 applies) after the first in a single course of treatment (See para AN.0.70 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20 **Extended Medicare Safety Net Cap:** $229.95
117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the attendance is not a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $300 or more For any particular patient, once only on the same day **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20 **Extended Medicare Safety Net Cap:** $229.95
119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner-each minor attendance after the first in a single course of treatment (See para AN.0.21, AN.0.70 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner—an attendance after the first attendance in a single course of treatment, if: (a) the attendance is a minor attendance; and (b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is $300 or more For any particular patient, once only on the same day (See para AN.0.21 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment **Fee:** $185.85 **Benefit:** 75% = $139.40 85% = $158.00 **Extended Medicare Safety Net Cap:** $500.00
128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner-each attendance (other than a service to which item 131 applies) after the first in a single course of treatment **Fee:** $112.40 **Benefit:** 75% = $84.30 85% = $95.55 **Extended Medicare Safety Net Cap:** $337.20
131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of his or her specialty (other than psychiatry) following referral of the patient to him or her by a referring practitioner-each minor attendance after the first in a single course of treatment (See para AN.0.21 of explanatory notes to this Category) **Fee:** $80.95 **Benefit:** 75% = $60.75 85% = $68.85 **Extended Medicare Safety Net Cap:** $242.85
132	Professional attendance by a consultant physician in the practice of his or her specialty (other than psychiatry) of at least 45 minutes in duration for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a consultant physician treatment and management plan of significant complexity is prepared and

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	provided to the referring practitioner, which involves: (i) an opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) medication recommendations; and (c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and (d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician Not being an attendance on the patient in respect of whom, in the preceding 12 months, payment has been made under this item for attendance by the same consultant physician. (See para AN.0.23 of explanatory notes to this Category) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70 **Extended Medicare Safety Net Cap:** $500.00
133	Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where a) a review is undertaken that covers: - review of initial presenting problem/s and results of diagnostic investigations - review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment, - review of original and differential diagnoses; and b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate: - a revised opinion on the diagnosis and risk assessment - treatment options and decisions - revised medication recommendations Not being an attendance on a patient in respect of whom, an attendance under item 110, 116 and 119 has been received on the same day by the same consultant physician or locum tenens. Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 132. Item 133 can be provided by either the same consultant physician or a locum tenens.

A4. CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Payable no more than twice in any 12 month period. (See para AN.0.23 of explanatory notes to this Category) **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00 **Extended Medicare Safety Net Cap:** $402.30
A5. PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A5. Prolonged Attendances To Which No Other Item Applies
	PROLONGED PROFESSIONAL ATTENDANCE Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death. The time period relates to the total time spent with a single patient, even if the time spent by the practitioner is not continuous. Attendance on one patient at risk of imminent death may be provided by one or more general practitioners, specialists or consultant physicians on the one occasion.
160	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $221.50 **Benefit:** 75% = $166.15 100% = $221.50 **Extended Medicare Safety Net Cap:** $500.00
161	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $369.15 **Benefit:** 75% = $276.90 100% = $369.15 **Extended Medicare Safety Net Cap:** $500.00
162	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $516.65 **Benefit:** 75% = $387.50 100% = $516.65 **Extended Medicare Safety Net Cap:** $500.00
163	Professional attendance by a general practitioner, specialist or consultant physician for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $664.55 **Benefit:** 75% = $498.45 100% = $664.55 **Extended Medicare Safety Net Cap:** $500.00
164	Professional attendance by a general practitioner, specialist or consultant physician for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.0.27 of explanatory notes to this Category) **Fee:** $738.40 **Benefit:** 75% = $553.80 100% = $738.40 **Extended Medicare Safety Net Cap:** $500.00
A6. GROUP THERAPY	

A6. GROUP THERAPY	
	Group A6. Group Therapy
170	Professional attendance for the purpose of Group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of his or her speciality of psychiatry) involving members of a family and persons with close personal relationships with that family-each Group of 2 patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $117.55 **Benefit:** 75% = $88.20 100% = $117.55 **Extended Medicare Safety Net Cap:** $352.65
171	Professional attendance for the purpose of Group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each Group of 3 patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $123.85 **Benefit:** 75% = $92.90 100% = $123.85 **Extended Medicare Safety Net Cap:** $371.55
172	Professional attendance for the purpose of Group therapy of not less than 1 hour in duration given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of his or her specialty of psychiatry) involving members of a family and persons with close personal relationships with that family-each Group of 4 or more patients (See para AN.0.28, AN.0.5 of explanatory notes to this Category) **Fee:** $150.70 **Benefit:** 75% = $113.05 100% = $150.70 **Extended Medicare Safety Net Cap:** $452.10

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS — 1. ACUPUNCTURE	
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 1. Acupuncture
173	Professional attendance at which acupuncture is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture was performed (See para AN.0.29 of explanatory notes to this Category) **Fee:** $21.65 **Benefit:** 75% = $16.25 100% = $21.65 **Extended Medicare Safety Net Cap:** $64.95
193	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is

	performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
195	Professional attendance by a general practitioner who is a qualified medical acupuncturist, on one or more patients at a hospital, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 193, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
197	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place other than a hospital, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
199	Professional attendance by a general practitioner who is a qualified medical acupuncturist, at a place

	other than a hospital, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the qualified medical acupuncturist by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed (See para AN.0.29, AN.0.9 of explanatory notes to this Category) **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 2. Non-Specialist Practitioner attendances to which no other item applies
179	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area. (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Fee:** $13.75 **Benefit:** 100% = $13.75 **Extended Medicare Safety Net Cap:** $41.25
Fee 181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies), not more than 5 minutes in duration—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 179, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 179 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 183	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of not more than 5 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 179, plus $37.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 179 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. NON-SPECIALIST PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
185	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Fee:** $30.10 **Benefit:** 100% = $30.10 **Extended Medicare Safety Net Cap:** $90.30
Fee 187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 185, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 185 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 188	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 185, plus $37.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 185 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
189	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Fee:** $58.25 **Benefit:** 100% = $58.25 **Extended Medicare Safety Net Cap:** $174.75
Fee 191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 189, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 189 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 202	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category)

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	2. NON-SPECIALIST PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Derived Fee: The fee for item 189, plus $37.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 189 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
203	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which any other item applies)—each attendance, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Fee:** $85.70 **Benefit:** 100% = $85.70 **Extended Medicare Safety Net Cap:** $257.10
Fee 206	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in the table applies) of more than 45 minutes in duration—an attendance on one or more patients at one place on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 203, plus $21.10 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 203 plus $1.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
Fee 212	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (that is not accommodation in a self contained unit) of more than 45 minutes in duration—an attendance on one or more patients at one residential aged care facility on one occasion—each patient, by a medical practitioner in an eligible area (See para GN.7.17, AN.7.1, AN.7.2 of explanatory notes to this Category) **Derived Fee:** The fee for item 203, plus $37.90 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 203 plus $2.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. NON-SPECIALIST PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 3. Non-Specialist Practitioner prolonged attendances to which no other item applies
214	Professional attendance by a medical practitioner for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $177.20 **Benefit:** 75% = $132.90 100% = $177.20 **Extended Medicare Safety Net Cap:** $500.00
215	Professional attendance by a medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $295.30 **Benefit:** 75% = $221.50 100% = $295.30 **Extended Medicare Safety Net Cap:** $500.00
218	Professional attendance by a medical practitioner for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	3. NON-SPECIALIST PRACTITIONER PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	(See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $413.30 **Benefit:** 75% = $310.00 100% = $413.30 **Extended Medicare Safety Net Cap:** $500.00
219	Professional attendance by a medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $531.65 **Benefit:** 75% = $398.75 100% = $531.65 **Extended Medicare Safety Net Cap:** $500.00
220	Professional attendance by a medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death (See para AN.7.1, AN.7.3 of explanatory notes to this Category) **Fee:** $590.70 **Benefit:** 75% = $443.05 100% = $590.70 **Extended Medicare Safety Net Cap:** $500.00

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	4. NON-SPECIALIST PRACTITIONER GROUP THERAPY
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 4. Non-Specialist Practitioner group therapy
221	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family—each Group of 2 patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $94.05 **Benefit:** 75% = $70.55 100% = $94.05 **Extended Medicare Safety Net Cap:** $282.15
222	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family—each Group of 3 patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $99.10 **Benefit:** 75% = $74.35 100% = $99.10 **Extended Medicare Safety Net Cap:** $297.30
223	Professional attendance for the purpose of group therapy of not less than 1 hour in duration given under the direct continuous supervision of a medical practitioner involving members of a family and persons with close personal relationships with that family—each Group of 4 or more patients (See para AN.7.1, AN.7.4 of explanatory notes to this Category) **Fee:** $120.55 **Benefit:** 75% = $90.45 100% = $120.55 **Extended Medicare Safety Net Cap:** $361.65

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	5. NON-SPECIALIST PRACTITIONER HEALTH ASSESSMENTS
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 5. Non-Specialist Practitioner health assessments
224	Professional attendance by a medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and

	(b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $47.50 **Benefit:** 100% = $47.50 **Extended Medicare Safety Net Cap:** $142.50
225	Professional attendance by a medical practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $110.30 **Benefit:** 100% = $110.30 **Extended Medicare Safety Net Cap:** $330.90
226	Professional attendance by a medical practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $152.25 **Benefit:** 100% = $152.25 **Extended Medicare Safety Net Cap:** $456.75
227	Professional attendance by a medical practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient (See para AN.7.1, AN.7.5, AN.7.6, AN.7.7, AN.7.8, AN.7.9, AN.7.10, AN.7.11, AN.7.12 of explanatory notes to this Category) **Fee:** $215.05 **Benefit:** 100% = $215.05 **Extended Medicare Safety Net Cap:** $500.00

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	5. NON-SPECIALIST PRACTITIONER HEALTH ASSESSMENTS
228	Professional attendance by a medical practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—this item or item 715 not more than once in a 9 month period (See para AN.7.1, AN.7.13, AN.7.14, AN.7.15, AN.7.16 of explanatory notes to this Category) **Fee:** $169.80 **Benefit:** 100% = $169.80 **Extended Medicare Safety Net Cap:** $500.00

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	6. NON-SPECIALIST PRACTITIONER MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 6. Non-Specialist Practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences
229	Attendance by a medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $115.40 **Benefit:** 75% = $86.55 100% = $115.40 **Extended Medicare Safety Net Cap:** $346.20
230	Attendance by a medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $91.45 **Benefit:** 75% = $68.60 100% = $91.45 **Extended Medicare Safety Net Cap:** $274.35
231	Contribution by a medical practitioner, to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $56.30 **Benefit:** 75% = $42.25 100% = $56.30 **Extended Medicare Safety Net Cap:** $168.90
232	Contribution by a medical practitioner, to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 and items 235 to 240 apply) (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $56.30 **Benefit:** 75% = $42.25 100% = $56.30 **Extended Medicare Safety Net Cap:** $168.90
233	Attendance by a medical practitioner to review or coordinate a review of: (a) a GP management plan prepared by a medical practitioner (or an associated medical practitioner) to which item 721 or item 229 applies; or

	(b) team care arrangements which have been coordinated by the medical practitioner (or an associated medical practitioner) to which item 723 or item 230 applies (See para AN.7.1, AN.7.17 of explanatory notes to this Category) **Fee:** $57.65 **Benefit:** 75% = $43.25 100% = $57.65 **Extended Medicare Safety Net Cap:** $172.95
235	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $56.50 **Benefit:** 75% = $42.40 100% = $56.50 **Extended Medicare Safety Net Cap:** $169.50
236	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $96.75 **Benefit:** 75% = $72.60 100% = $96.75 **Extended Medicare Safety Net Cap:** $290.25
237	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $161.30 **Benefit:** 75% = $121.00 100% = $161.30 **Extended Medicare Safety Net Cap:** $483.90
238	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in:

	(a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $41.50 **Benefit:** 75% = $31.15 100% = $41.50 **Extended Medicare Safety Net Cap:** $124.50
239	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $71.20 **Benefit:** 75% = $53.40 100% = $71.20 **Extended Medicare Safety Net Cap:** $213.60
240	Attendance by a medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 or items 229 to 233 apply) (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $118.55 **Benefit:** 75% = $88.95 100% = $118.55 **Extended Medicare Safety Net Cap:** $355.65
243	Attendance by a medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $65.20 **Benefit:** 75% = $48.90 100% = $65.20 **Extended Medicare Safety Net Cap:** $195.60
244	Attendance by a medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	**6. NON-SPECIALIST PRACTITIONER MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES**
	practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.7.1, AN.7.27 of explanatory notes to this Category) **Fee:** $30.35 **Benefit:** 75% = $22.80 100% = $30.35 **Extended Medicare Safety Net Cap:** $91.05
A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	**7. NON-SPECIALIST PRACTITIONER DOMICILIARY AND RESIDENTIAL MEDICATION MANAGEMENT REVIEW**
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 7. Non-Specialist Practitioner domiciliary and residential medication management review
245	Participation by a medical practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the medical practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and (d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—this item or item 900 is applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.7.1, AN.7.18 of explanatory notes to this Category) **Fee:** $123.85 **Benefit:** 100% = $123.85 **Extended Medicare Safety Net Cap:** $371.55
249	Participation by a medical practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR (See para AN.7.1, AN.7.18 of explanatory notes to this Category) **Fee:** $84.80 **Benefit:** 100% = $84.80 **Extended Medicare Safety Net Cap:** $254.40

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 8. Non-Specialist Practitioner attendances associated with Practice Incentive Program payments
251	Professional attendance at consulting rooms of less than 5 minutes in duration by a medical practitioner in an eligible area at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $13.55 **Benefit:** 100% = $13.55 **Extended Medicare Safety Net Cap:** $40.65
252	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $29.65 **Benefit:** 100% = $29.65 **Extended Medicare Safety Net Cap:** $88.95
253	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Derived Fee:** The fee for item 252, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 252 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
254	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 100% = $57.35 **Extended Medicare Safety Net Cap:** $172.05
255	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Derived Fee:** The fee for item 254, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 254 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
256	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical

	practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Fee:** $84.45 **Benefit:** 100% = $84.45 **Extended Medicare Safety Net Cap:** $253.35
257	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.7.1, AN.7.19 of explanatory notes to this Category) **Derived Fee:** The fee for item 256, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 256 plus $1.60 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
259	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Fee:** $29.65 **Benefit:** 100% = $29.65 **Extended Medicare Safety Net Cap:** $88.95
260	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Derived Fee:** The fee for item 259, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 259 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
261	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 100% = $57.35 **Extended Medicare Safety Net Cap:** $172.05
262	Professional attendance at a place other than consulting rooms of more than 25 minutes but not more than 45 minutes, in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Derived Fee:** The fee for item 261, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 261 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
263	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category)

	Fee: $84.45 **Benefit:** 100% = $84.45 **Extended Medicare Safety Net Cap:** $253.35
264	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.7.1, AN.7.20 of explanatory notes to this Category) **Derived Fee:** The fee for item 263, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 263 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
265	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Fee:** $29.65 **Benefit:** 100% = $29.65 **Extended Medicare Safety Net Cap:** $88.95
266	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Derived Fee:** The fee for item 265, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 265 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
268	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 100% = $57.35 **Extended Medicare Safety Net Cap:** $172.05
269	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Derived Fee:** The fee for item 268, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 268 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
270	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category) **Fee:** $84.45 **Benefit:** 100% = $84.45 **Extended Medicare Safety Net Cap:** $253.35
271	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner in an eligible area, that completes the minimum requirements of the Asthma Cycle of Care (See para AN.7.1, AN.7.21 of explanatory notes to this Category)

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	8. NON-SPECIALIST PRACTITIONER ATTENDANCES ASSOCIATED WITH PRACTICE INCENTIVE PROGRAM PAYMENTS
	Derived Fee: The fee for item 270, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 270 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	**9. NON-SPECIALIST PRACTITIONER MENTAL HEALTH CARE**
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 9. Non-Specialist Practitioner mental health care
272	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.1, AN.7.22 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 75% = $43.05 100% = $57.35 **Extended Medicare Safety Net Cap:** $172.05
276	Professional attendance by a medical practitioner (who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $84.45 **Benefit:** 75% = $63.35 100% = $84.45 **Extended Medicare Safety Net Cap:** $253.35
277	Professional attendance by a medical practitioner to review a GP mental health treatment plan which he or she, or an associated medical practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 75% = $43.05 100% = $57.35 **Extended Medicare Safety Net Cap:** $172.05
279	Professional attendance by a medical practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $57.35 **Benefit:** 75% = $43.05 100% = $57.35 **Extended Medicare Safety Net Cap:** $172.05
281	Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $72.85 **Benefit:** 75% = $54.65 100% = $72.85 **Extended Medicare Safety Net Cap:** $218.55
282	Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.7.22, AN.7.1 of explanatory notes to this Category) **Fee:** $107.30 **Benefit:** 75% = $80.50 100% = $107.30 **Extended Medicare Safety Net Cap:** $321.90
283	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting

	at least 30 minutes, but less than 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Fee:** $74.20 **Benefit:** 100% = $74.20 **Extended Medicare Safety Net Cap:** $222.60
285	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 283, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 283 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
286	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Fee:** $106.20 **Benefit:** 100% = $106.20 **Extended Medicare Safety Net Cap:** $318.60
287	Professional attendance at a place other than consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 286, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 286 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 371	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner. (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Fee:** $74.20 **Benefit:** 100% = $74.20 **Extended Medicare Safety Net Cap:** $222.60
New 372	Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes if:

	(a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner. (See para AN.7.23, AN.7.1 of explanatory notes to this Category) **Fee:** $106.20 **Benefit:** 100% = $106.20 **Extended Medicare Safety Net Cap:** $318.60

	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 10. Non-Specialist Practitioner after-hours attendances to which no other item applies
733	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Fee:** $23.20 **Benefit:** 100% = $23.20 **Extended Medicare Safety Net Cap:** $69.60
737	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Fee:** $39.20 **Benefit:** 100% = $39.20 **Extended Medicare Safety Net Cap:** $117.60
741	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Fee:** $67.15 **Benefit:** 100% = $67.15 **Extended Medicare Safety Net Cap:** $201.45
745	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner—each attendance (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Fee:** $94.20 **Benefit:** 100% = $94.20 **Extended Medicare Safety Net Cap:** $282.60
761	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
763	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital

	or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
766	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
769	Professional attendance by a medical practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes—an attendance on one or more patients on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
772	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of not more than 5 minutes in duration by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 733, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 733 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
776	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 737, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 737 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
788	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	10. NON-SPECIALIST PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
	consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 741, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 741 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
789	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self contained unit) of more than 45 minutes in duration by a medical practitioner—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (See para AN.7.24, GN.7.17, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 745, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 745 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	11. NON-SPECIALIST PRACTITIONER PREGNANCY SUPPORT COUNSELLING
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 11. Non-Specialist Practitioner pregnancy support counselling
792	Professional attendance of at least 20 minutes in duration at consulting rooms by a medical practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or items 4001, 81000, 81005 or 81010 applies in relation to that pregnancy (See para AN.7.25, AN.7.1 of explanatory notes to this Category) **Fee:** $61.30 **Benefit:** 100% = $61.30 **Extended Medicare Safety Net Cap:** $183.90

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	12. NON-SPECIALIST PRACTITIONER VIDEO CONFERENCING CONSULTATION
	Group A7. Acupuncture and Non-Specialist Practitioner Items
	Subgroup 12. Non-Specialist Practitioner video conferencing consultation
812	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and

	(c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Fee:** $18.30 **Benefit:** 100% = $18.30 **Extended Medicare Safety Net Cap:** $54.90
827	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 812, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 812 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
829	Professional attendance of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 812, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 812 plus $2.65 per patient.

	Extended Medicare Safety Net Cap: 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
867	Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Fee:** $39.95 **Benefit:** 100% = $39.95 **Extended Medicare Safety Net Cap:** $119.85
868	Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 867, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 867 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
869	Professional attendance of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who:

	(a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 867, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 867 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
873	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Fee:** $77.50 **Benefit:** 100% = $77.50 **Extended Medicare Safety Net Cap:** $232.50
876	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a);

	for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 873, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 873 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
881	Professional attendance of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 873, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 873 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
885	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Fee:** $114.00 **Benefit:** 100% = $114.00 **Extended Medicare Safety Net Cap:** $342.00
891	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and

	(c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance—at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 885, plus $20.75 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 885 plus $1.60 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
892	Professional attendance of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion—each patient (See para AN.7.26, AN.7.1 of explanatory notes to this Category) **Derived Fee:** The fee for item 885, plus $37.35 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 885 plus $2.65 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 894	Professional attendance at consulting rooms by a medical practitioner, lasting more than 5 minutes but not more than 25 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the medical practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner; and (e) the patient has an existing relationship with the medical practitioner. **Fee:** $35.40 **Benefit:** 85% = $30.10 **Extended Medicare Safety Net Cap:** $106.20
New 896	Professional attendance at consulting rooms by a medical practitioner, lasting more than 25 minutes but not more than 45 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and

A7. ACUPUNCTURE AND NON-SPECIALIST PRACTITIONER ITEMS	12. NON-SPECIALIST PRACTITIONER VIDEO CONFERENCING CONSULTATION
	(c) the patient and the medical practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner; and (e) the patient has an existing relationship with the medical practitioner. **Fee:** $68.50 **Benefit:** 85% = $58.25 **Extended Medicare Safety Net Cap:** $205.50
New 898	Professional attendance at consulting rooms by a medical practitioner, lasting more than 45 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the medical practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the medical practitioner; and (e) the patient has an existing relationship with the medical practitioner. **Fee:** $100.80 **Benefit:** 85% = $85.70 **Extended Medicare Safety Net Cap:** $302.40
A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A8. Consultant Psychiatrist Attendances To Which No Other Item Applies
288	Professional attendance on a patient by a consultant physician practising in his or her specialty of psychiatry if: (a) the attendance is by video conference; and (b) item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352 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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service;

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 291, 293,296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352.Benefit: 85% of derived fee. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
289	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of psychiatry, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with autism or another pervasive developmental disorder, if the consultant psychiatrist does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medication recommendations; (c) provides a copy of the treatment and management plan to the referring practitioner; (d) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 139) (See para AN.0.24 of explanatory notes to this Category) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70 **Extended Medicare Safety Net Cap:** $500.00
291	Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred for the provision of an assessment and management plan by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or participating nurse practitioner, where the attendance is initiated by the referring practitioner and where the consultant psychiatrist provides the referring practitioner with an assessment and management plan to be undertaken by that practitioner for the patient, where clinically appropriate. An attendance of more than 45 minutes duration at consulting rooms during which: - An outcome tool is used where clinically appropriate - A mental state examination is conducted - A psychiatric diagnosis is made - The consultant psychiatrist decides that the patient can be appropriately managed by the referring

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	practitioner without the need for ongoing treatment by the psychiatrist - A 12 month management plan, appropriate to the diagnosis, is provided to the referring practitioner which must: a) comprehensively evaluate biological, psychological and social issues; b) address diagnostic psychiatric issues; c) make management recommendations addressing biological, psychological and social issues; and d) be provided to the referring practitioner within two weeks of completing the assessment of the patient. - The diagnosis and management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - The diagnosis and management plan is communicated in writing to the referring practitioner Not being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under this item (See para AN.0.30 of explanatory notes to this Category) **Fee:** $459.45 **Benefit:** 85% = $390.55 **Extended Medicare Safety Net Cap:** $500.00
293	Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY to review a management plan previously prepared by that consultant psychiatrist for a patient and claimed under item 291, where the review is initiated by the referring medical practitioner practising in general practice or participating nurse practitioner. An attendance of more than 30 minutes but not more than 45 minutes duration at consulting rooms where that attendance follows item 291 and during which: - An outcome tool is used where clinically appropriate - A mental state examination is conducted - A psychiatric diagnosis is made - A management plan provided under Item 291 is reviewed and revised - The reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - The reviewed management plan is communicated in writing to the referring medical practitioner or participating nurse practitioner Being an attendance on a patient in respect of whom, in the preceding 12 months, payment has been made under item 291, and no payment has been made under item 359, payable no more than once in any 12 month period. (See para AN.0.30 of explanatory notes to this Category) **Fee:** $287.20 **Benefit:** 85% = $244.15 **Extended Medicare Safety Net Cap:** $500.00
296	Professional attendance of more than 45 minutes in duration by a consultant physician in the practice of

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	his or her speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at consulting rooms if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 297 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (See para AN.0.30 of explanatory notes to this Category) **Fee:** $264.20 **Benefit:** 75% = $198.15 85% = $224.60 **Extended Medicare Safety Net Cap:** $500.00
297	Professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 299, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (H) (See para AN.0.30 of explanatory notes to this Category) **Fee:** $264.20 **Benefit:** 75% = $198.15 85% = $224.60 **Extended Medicare Safety Net Cap:** $500.00
299	Professional attendance of more than 45 minutes by a consultant physician in the practice of his or her speciality of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant psychiatrist; or (b) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; other than attendance on a patient in relation to whom this item, item 296 or 297, or any of items 300 to 346, 353 to 358 and 361 to 370, has applied in the preceding 24 months (See para AN.0.30 of explanatory notes to this Category) **Fee:** $315.95 **Benefit:** 75% = $237.00 85% = $268.60 **Extended Medicare Safety Net Cap:** $500.00
300	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40 **Extended Medicare Safety Net Cap:** $132.00
302	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60 **Extended Medicare Safety Net Cap:** $263.25
304	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $135.10 **Benefit:** 75% = $101.35 85% = $114.85 **Extended Medicare Safety Net Cap:** $405.30
306	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $186.40 **Benefit:** 75% = $139.80 85% = $158.45 **Extended Medicare Safety Net Cap:** $500.00
308	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms), if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies have not exceeded 50 attendances in a calendar year for the patient **Fee:** $216.35 **Benefit:** 75% = $162.30 85% = $183.90 **Extended Medicare Safety Net Cap:** $500.00
310	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $21.90 **Benefit:** 75% = $16.45 85% = $18.65 **Extended Medicare Safety Net Cap:** $65.70
312	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40 **Extended Medicare Safety Net Cap:** $132.00
314	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $202.95
316	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $93.35 **Benefit:** 75% = $70.05 85% = $79.35 **Extended Medicare Safety Net Cap:** $280.05
318	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at consulting rooms, if that attendance and another attendance to which any of items 296, 300 to 308, 353 to 358 and 361 to 370 applies exceed 50 attendances in a calendar year for the patient **Fee:** $108.20 **Benefit:** 75% = $81.15 85% = $92.00 **Extended Medicare Safety Net Cap:** $324.60
319	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes in duration at consulting rooms, if the patient has: (a) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (b) for persons 18 years and over-been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale; if that attendance and another attendance to which any of items 296, 300 to 319, 353 to 358 and 361 to 370 applies have not exceeded 160 attendances in a calendar year for the patient (See para AN.0.31 of explanatory notes to this Category) **Fee:** $186.40 **Benefit:** 75% = $139.80 85% = $158.45 **Extended Medicare Safety Net Cap:** $500.00
320	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration at hospital **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40 **Extended Medicare Safety Net Cap:** $132.00
322	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration at hospital **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60 **Extended Medicare Safety Net Cap:** $263.25
324	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration at hospital **Fee:** $135.10 **Benefit:** 75% = $101.35 85% = $114.85 **Extended Medicare Safety Net Cap:** $405.30
326	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration at hospital **Fee:** $186.40 **Benefit:** 75% = $139.80 85% = $158.45 **Extended Medicare Safety Net Cap:** $500.00
328	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration at hospital **Fee:** $216.35 **Benefit:** 75% = $162.30 85% = $183.90 **Extended Medicare Safety Net Cap:** $500.00
330	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of not more than 15 minutes in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $80.75 **Benefit:** 75% = $60.60 85% = $68.65 **Extended Medicare Safety Net Cap:** $242.25
332	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 15 minutes, but not more than 30 minutes, in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $126.50 **Benefit:** 75% = $94.90 85% = $107.55 **Extended Medicare Safety Net Cap:** $379.50
334	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 30 minutes, but not more than 45 minutes, in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $184.35 **Benefit:** 75% = $138.30 85% = $156.70 **Extended Medicare Safety Net Cap:** $500.00
336	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 45 minutes, but not more than 75 minutes, in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $223.05 **Benefit:** 75% = $167.30 85% = $189.60 **Extended Medicare Safety Net Cap:** $500.00
338	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry following referral of the patient to him or her by a referring practitioner-an attendance of more than 75 minutes in duration if that attendance is at a place other than consulting rooms or hospital **Fee:** $253.30 **Benefit:** 75% = $190.00 85% = $215.35 **Extended Medicare Safety Net Cap:** $500.00
342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which Group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a Group of 2 to 9 unrelated patients or a family Group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5 of explanatory notes to this Category) **Fee:** $50.05 **Benefit:** 75% = $37.55 85% = $42.55

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $150.15
344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which Group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family Group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5 of explanatory notes to this Category) **Fee:** $66.45 **Benefit:** 75% = $49.85 85% = $56.50 **Extended Medicare Safety Net Cap:** $199.35
346	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which Group therapy is conducted) of not less than 1 hour in duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry, involving a family Group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner-each patient (See para AN.0.5 of explanatory notes to this Category) **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55 **Extended Medicare Safety Net Cap:** $294.75
348	Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a referring practitioner involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility (See para AN.0.32, AN.0.5 of explanatory notes to this Category) **Fee:** $128.65 **Benefit:** 75% = $96.50 85% = $109.40 **Extended Medicare Safety Net Cap:** $385.95
350	Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a referring practitioner involving an interview of a person other than the patient of not less 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility (See para AN.0.32, AN.0.5 of explanatory notes to this Category) **Fee:** $177.60 **Benefit:** 75% = $133.20 85% = $151.00 **Extended Medicare Safety Net Cap:** $500.00
352	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a referring practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period (See para AN.0.32, AN.0.5 of explanatory notes to this Category) **Fee:** $128.65 **Benefit:** 75% = $96.50 85% = $109.40 **Extended Medicare Safety Net Cap:** $385.95
353	A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of PSYCHIATRY (not being an attendance to which items 291 to 319 apply), where: -the patient is referred to him or her by a referring practitioner for assessment, diagnosis and/or treatment and is located in a regional, rural or remote area (RRMA3-7), -that consultation and any other consultation to which items 353 to 361 apply, have not exceeded 12 consultations in a calendar year,

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	-any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. A telepsychiatry consultation of not more than 15 minutes duration. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $58.05 **Benefit:** 75% = $43.55 85% = $49.35 **Extended Medicare Safety Net Cap:** $174.15
355	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $116.15 **Benefit:** 75% = $87.15 85% = $98.75 **Extended Medicare Safety Net Cap:** $348.45
356	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $170.30 **Benefit:** 75% = $127.75 85% = $144.80 **Extended Medicare Safety Net Cap:** $500.00
357	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration (See para AN.0.59 of explanatory notes to this Category) **Fee:** $234.90 **Benefit:** 75% = $176.20 85% = $199.70 **Extended Medicare Safety Net Cap:** $500.00
358	A telepsychiatry consultation of more than 75 minutes duration (See para AN.0.59 of explanatory notes to this Category) **Fee:** $286.25 **Benefit:** 75% = $214.70 85% = $243.35 **Extended Medicare Safety Net Cap:** $500.00
359	A telepsychiatry consultation of more than 30 minutes but not more than 45 minutes duration by a consultant physician in the practice of his or her specialty of PSYCHIATRY where: - the patient is located in a regional, rural or remote area (RRMA 3-7) - in the preceding 12 months, payment has been made under item 291 - an outcome tool is used where clinically appropriate - a mental state examination is conducted - a psychiatric diagnosis is made - a management plan provided under Item 291 is reviewed and revised - the reviewed management plan is explained and provided, unless clinically inappropriate, to the patient and/or the carer (with the patient's agreement) - the reviewed management plan is communicated in writing to the referring practitioner Not being an attendance on a patient in respect of whom payment has been made under this item or item 293 in the preceding 12 month period. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $330.25 **Benefit:** 75% = $247.70 85% = $280.75 **Extended Medicare Safety Net Cap:** $500.00
361	Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	following referral of the patient to him or her by a referring practitioner-a telepsychiatry consultation of more than 45 minutes in duration, if the patient: (a) either: (i) is a new patient for this consultant psychiatrist; or (ii) has not received a professional attendance from this consultant psychiatrist in the preceding 24 months; and (b) is located in a regional, rural or remote area; other than attendance on a patient in relation to whom this item, item 296, 297 or 299, or any of items 300 to 346 and 353 to 370, has applied in the preceding 24 month period (See para AN.0.59 of explanatory notes to this Category) **Fee:** $303.80 **Benefit:** 75% = $227.85 85% = $258.25 **Extended Medicare Safety Net Cap:** $500.00
364	Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, where: - the patient is referred to him or her by a referring practitioner, - that attendance occurs following a telepsychiatry consultation (items 353 to 361), - that attendance and any other attendance to which items 300 to 308 and 353 to 358 or 361 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. These items may only be used after telepsychiatry consultation(s) have been conducted in accordance with items 353 to 361. A face-to-face attendance of not more than 15 minutes duration. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $44.00 **Benefit:** 75% = $33.00 85% = $37.40 **Extended Medicare Safety Net Cap:** $132.00
366	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration (See para AN.0.59 of explanatory notes to this Category) **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60 **Extended Medicare Safety Net Cap:** $263.25
367	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $135.10 **Benefit:** 75% = $101.35 85% = $114.85 **Extended Medicare Safety Net Cap:** $405.30
369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration (See para AN.0.59 of explanatory notes to this Category) **Fee:** $186.55 **Benefit:** 75% = $139.95 85% = $158.60 **Extended Medicare Safety Net Cap:** $500.00
370	A face-to-face attendance of more than 75 minutes duration. (See para AN.0.59 of explanatory notes to this Category) **Fee:** $216.35 **Benefit:** 75% = $162.30 85% = $183.90

A8. CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $500.00
A9. CONTACT LENSES - ATTENDANCES	
	Group A9. Contact Lenses - Attendances
10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10805	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of

A9. CONTACT LENSES - ATTENDANCES	
	dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity-whether congenital, traumatic or surgical in origin (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient who, because of physical deformity, are unable to wear spectacles (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription-one service in any period of 36 months-patient with a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account (See para AN.0.34 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply (See para AN.0.35 of explanatory notes to this Category) **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95 **Extended Medicare Safety Net Cap:** $370.35

A10. OPTOMETRICAL SERVICES	1. GENERAL
	Group A10. Optometrical Services
	Subgroup 1. General
10905	REFERRED COMPREHENSIVE INITIAL CONSULTATION Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10907	COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER Professional attendance of more than 15 minutes in duration, being the first in a course of attention if the patient has attended another optometrist for an attendance to which this item or item 10905, 10910, 10911, 10912, 10913, 10914 or 10915 applies, or to which old item 10900 applied: (a) for a patient who is less than 65 years of age-within the previous 36 months; or

	(b) for a patient who is at least 65 years or age-within the previous 12 months (See para AN.0.10 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10910	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS LESS THAN 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is less than 65 years of age; and (b) the patient has not, within the previous 36 months, received a service to which: (i) this item or item 10905, 10907, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10911	COMPREHENSIVE INITIAL CONSULTATION - PATIENT IS AT LEAST 65 YEARS OF AGE Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if: (a) the patient is at least 65 years of age; and (b) the patient has not, within the previous 12 months, received a service to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913, 10914 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10912	OTHER COMPREHENSIVE CONSULTATIONS Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has suffered a significant change of visual function requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10913, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10913	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if

	the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10914 or 10915 at the same practice applies; or (ii) old item 10900 at the same practice applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10914	Professional attendance of more than 15 minutes in duration, being the first in a course of attention, if the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment: (a) for a patient who is less than 65 years of age-within 36 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied; or (b) for a patient who is at least 65 years of age-within 12 months of an initial consultation to which: (i) this item, or item 10905, 10907, 10910, 10911, 10912, 10913 or 10915 applies; or (ii) old item 10900 applied (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10915	Professional attendance of more than 15 minutes duration, being the first in a course of attention involving the examination of the eyes, with the instillation of a mydriatic, of a patient with diabetes mellitus requiring comprehensive reassessment. (See para AN.0.10 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10916	BRIEF INITIAL CONSULTATION Professional attendance, being the first in a course of attention, of not more than 15 minutes duration, not being a service associated with a service to which item 10931, 10932, 10933, 10940, 10941, 10942 or 10943 applies (See para AN.0.10 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10918	SUBSEQUENT CONSULTATION Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses, not being a service associated with a service to which item

	10940 or 10941 applies (See para AN.0.10 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10921	CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS - BULK ITEMS FOR ALL SUBSEQUENT CONSULTATIONS All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $165.80 **Benefit:** 85% = $140.95
10922	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $165.80 **Benefit:** 85% = $140.95
10923	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with astigmatism of 3.0 dioptres or greater in one eye (See para AN.0.2 of explanatory notes to this Category) **Fee:** $165.80 **Benefit:** 85% = $140.95
10924	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or

	(b) old item 10900 applied Payable once in a period of 36 months for - patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para AN.0.2 of explanatory notes to this Category) **Fee:** $209.20 **Benefit:** 85% = $177.85
10925	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para AN.0.2 of explanatory notes to this Category) **Fee:** $165.80 **Benefit:** 85% = $140.95
10926	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system (See para AN.0.2 of explanatory notes to this Category) **Fee:** $165.80 **Benefit:** 85% = $140.95
10927	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: i. pathological mydriasis; or ii. aniridia; or

	iii. coloboma of the iris; or iv. pupillary malformation or distortion; or v. significant ocular deformity or corneal opacity -whether congenital, traumatic or surgical in origin (See para AN.0.2 of explanatory notes to this Category) **Fee:** $209.20 **Benefit:** 85% = $177.85
10928	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who, because of physical deformity, are unable to wear spectacles (See para AN.0.2 of explanatory notes to this Category) **Fee:** $165.80 **Benefit:** 85% = $140.95
10929	All professional attendances after the first, being those attendances regarded as a single service, in a single course of attention involving the prescription and fitting of contact lenses, being a course of attention for which the first attendance is a service to which: (a) item 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915 or 10916 applies; or (b) old item 10900 applied Payable once in a period of 36 months for - patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10926, 10927 or 10928 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account *Note: Benefits may not be claimed under Item 10929 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons - see paragraph O6 of explanatory notes to this category.* (See para AN.0.2 of explanatory notes to this Category) **Fee:** $209.20 **Benefit:** 85% = $177.85
10930	All professional attendances regarded as a single service in a single course of attention involving the prescription and fitting of contact lenses where the patient meets the requirements of an item in the range 10921-10929 and requires a change in contact lens material or basic lens parameters, other than a simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens covered by item 10921 to 10929 **Fee:** $165.80 **Benefit:** 85% = $140.95
10931	DOMICILIARY VISITS An optometric service to which an item in Group A10 of this table (other than this item or item 10916,

	10932, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on one patient at a single location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category) **Fee:** $23.30 **Benefit:** 85% = $19.85
	An optometric service to which an item in Group A10 of this table (other than this item or item 10916, 10931, 10933, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on two patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category)
10932	**Fee:** $11.60 **Benefit:** 85% = $9.90
10933	An optometric service to which an item in Group A10 of this table (other than this item or item 10916,

	10931, 10932, 10940 or 10941) applies (the applicable item) if the service is: a) rendered at a place other than consulting rooms, being at: (i) a patient's home: or (ii) residential aged care facility: or (iii) an institution; and b) performed on three patients at the same location on one occasion, and c) either: (i) bulk-billed in respect of the fees for both: - this item; and - the applicable item; or (ii) not bulk-billed in respect of the fees for both: - this item; and - the applicable item (See para AN.0.10 of explanatory notes to this Category) **Fee:** $7.70 **Benefit:** 85% = $6.55
10940	COMPUTERISED PERIMETRY Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 10941 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies (See para AN.0.10, DN.1.6 of explanatory notes to this Category) **Fee:** $63.75 **Benefit:** 85% = $54.20
10941	Full quantitative computerised perimetry (automated absolute static threshold) not being a service involving multifocal multichannel objective perimetry, performed by an optometrist, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - to a maximum of 2 examinations (including examinations to which item 10940 applies) in any 12 month period, not being a service associated with a service to which item 10916, 10918, 10931, 10932 or 10933 applies (See para AN.0.10, DN.1.6 of explanatory notes to this Category) **Fee:** $38.45 **Benefit:** 85% = $32.70
10942	LOW VISION ASSESSMENT Testing of residual vision to provide optimum visual performance involving one or more of spectacle correction, determination of contrast sensitivity, determination of glare sensitivity and prescription of magnification aids in a patient who has best corrected visual acuity of 6/15 or N.12 or worse in the better

	eye, or horizontal visual field of less than 120 degrees within 10 degrees above and below the horizontal midline, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable twice in a 12 month period (See para AN.0.10 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10943	CHILDREN'S VISION ASSESSMENT Additional testing to confirm diagnosis of, or establish a treatment regime for, a significant binocular or accommodative dysfunction, including assessment of one or more of accommodation, ocular motility, vergences, or fusional reserves and/or cycloplegic refraction, in a patient aged 3 to 14 years, not to be used for the assessment of learning difficulties or learning disabilities, not being a service associated with a service to which item 10916 or 10921 to 10930 applies, payable once only in a 12 month period (See para AN.0.10 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10944	CORNEA, complete removal of embedded foreign body from - not more than once on the same day by the same practitioner (excluding aftercare) The item is not to be billed on the same occasion as MBS items 10905, 10907, 10910, 10911, 10912, 10913, 10914, 10915, 10916 or 10918. If the embedded foreign body is not completely removed, this item does not apply but item 10916 may apply. **Fee:** $72.15 **Benefit:** 85% = $61.35

	Group A10. Optometrical Services
	Subgroup 2. Telehealth Attendance
	TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
10945	A professional attendance of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies (See para AN.0.22 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10946	A professional attendance of at least 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist practising in his or her

A10. OPTOMETRICAL SERVICES	2. TELEHEALTH ATTENDANCE
	speciality of ophthalmology; and (b) is not an admitted patient; and (c) either: (i) is located within a telehealth eligible area and, at the time of the attendance, is at least 15 kilometres by road from the specialist mentioned in paragraph (a); or (ii) is a patient of an Aboriginal Medical Service, or an Aboriginal Community Controlled Health Service, for which a direction under subsection 19(2) of the Act applies (See para AN.0.22 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80
10947	A professional attendance (not being a service to which any other item applies) of less than 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and c) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion-each patient (See para AN.0.22 of explanatory notes to this Category) **Fee:** $33.45 **Benefit:** 85% = $28.45
10948	A professional attendance (not being a service to which any other item applies) of at least 15 minutes (whether or not continuous) by an attending optometrist that requires the provision of clinical support to a patient who: a) is participating in a video conferencing consultation with a specialist practising in his or her speciality of ophthalmology; and b) at the time of the attendance, is located at a residential aged care facility (whether or not at consulting rooms situated within the facility); and c) is a care recipient in the facility; and d) is not a resident of a self-contained unit; for an attendance on one occasion-each patient (See para AN.0.22 of explanatory notes to this Category) **Fee:** $66.80 **Benefit:** 85% = $56.80

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	Group A11. Urgent Attendance After Hours
	Subgroup 1. Urgent Attendance - After Hours
585	Professional attendance by a general practitioner on one patient on one occasion—each attendance

A11. URGENT ATTENDANCE AFTER HOURS	1. URGENT ATTENDANCE - AFTER HOURS
	(other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $129.80 **Benefit:** 75% = $97.35 100% = $129.80 **Extended Medicare Safety Net Cap:** $389.40
588	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $129.80 **Benefit:** 75% = $97.35 100% = $129.80 **Extended Medicare Safety Net Cap:** $389.40
591	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $100.00 **Benefit:** 75% = $75.00 100% = $100.00 **Extended Medicare Safety Net Cap:** $300.00
594	Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient (See para AN.0.9, AN.0.19 of explanatory notes to this Category) **Fee:** $41.95 **Benefit:** 75% = $31.50 100% = $41.95 **Extended Medicare Safety Net Cap:** $125.85

A11. URGENT ATTENDANCE AFTER HOURS	2. URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
	Group A11. Urgent Attendance After Hours

A11. URGENT ATTENDANCE AFTER HOURS	2. URGENT ATTENDANCE UNSOCIABLE AFTER HOURS
	Subgroup 2. Urgent Attendance Unsociable After Hours
599	Professional attendance by a general practitioner on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $153.00 **Benefit:** 75% = $114.75 100% = $153.00 **Extended Medicare Safety Net Cap:** $459.00
600	Professional attendance by a medical practitioner (other than a general practitioner) on not more than one patient on one occasion—each attendance in unsociable hours if: (a) the attendance is requested by the patient or a responsible person in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance (See para AN.0.19 of explanatory notes to this Category) **Fee:** $124.25 **Benefit:** 75% = $93.20 100% = $124.25 **Extended Medicare Safety Net Cap:** $372.75

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A12. Consultant Occupational Physician Attendances To Which No Other Item Applies
384	Initial professional attendance of 10 minutes or less in duration on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) 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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $65.15 **Benefit:** 85% = $55.40 **Extended Medicare Safety Net Cap:** $195.45
385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $86.85 **Benefit:** 75% = $65.15 85% = $73.85 **Extended Medicare Safety Net Cap:** $260.55
386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner-each attendance after the first in a single course of treatment (See para AN.0.33, AN.0.70 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $127.40 **Benefit:** 75% = $95.55 85% = $108.30 **Extended Medicare Safety Net Cap:** $382.20
388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine following referral of the patient to him or her by a referring practitioner-each attendance after the first in a single course of treatment (See para AN.0.33 of explanatory notes to this Category) **Fee:** $80.65 **Benefit:** 75% = $60.50 85% = $68.60 **Extended Medicare Safety Net Cap:** $241.95
389	Professional attendance on a patient by a consultant occupational physician practising in his or her specialty of occupational medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 385 lasting more than 10 minutes; or (ii) provided with item 386; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both:

A12. CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 kms by road from the physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 385 or 386. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A13. Public Health Physician Attendances To Which No Other Item Applies
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - AT CONSULTING ROOMS Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine
410	LEVEL A Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $19.85 **Benefit:** 75% = $14.90 85% = $16.90 **Extended Medicare Safety Net Cap:** $59.55
411	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90 **Extended Medicare Safety Net Cap:** $130.20

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
412	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $83.90 **Benefit:** 75% = $62.95 85% = $71.35 **Extended Medicare Safety Net Cap:** $251.70
413	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Fee:** $123.55 **Benefit:** 75% = $92.70 85% = $105.05 **Extended Medicare Safety Net Cap:** $370.65
	PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS Professional attendance other than at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine.
414	LEVEL A Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 410, plus $25.85 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
415	LEVEL B

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 411, plus $25.85 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
416	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 412, plus $25.85 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
417	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan;

A13. PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation. (See para AN.0.50 of explanatory notes to this Category) **Derived Fee:** The fee for item 413, plus $25.85 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A14. HEALTH ASSESSMENTS	
	Group A14. Health Assessments
	HEALTH ASSESSMENTS The category of people eligible for health assessments are : a) People aged 40 to 49 years (inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool b) People between the age of 45 and 49 (inclusive) who are at risk of developing a chronic disease c) People aged 75 years and older d) Permanent residents of a Residential Aged Care Facility e) People who have an intellectual disability f) Humanitarian entrants who are resident in Australia with access to Medicare services, including Refugees and Special Humanitarian Program and Protection Program entrants g) Former serving members of the Australian Defence Force including former members of permanent and reserve forces
701	Professional attendance by a general practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $59.35 **Benefit:** 100% = $59.35 **Extended Medicare Safety Net Cap:** $178.05
703	Professional attendance by a general practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $137.90 **Benefit:** 100% = $137.90 **Extended Medicare Safety Net Cap:** $413.70
705	Professional attendance by a general practitioner to perform a long health assessment, lasting at least 45

A14. HEALTH ASSESSMENTS	
	minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $190.30 **Benefit:** 100% = $190.30 **Extended Medicare Safety Net Cap:** $500.00
707	Professional attendance by a general practitioner to perform a prolonged health assessment (lasting at least 60 minutes) including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient (See para AN.0.40, AN.0.38, AN.0.42, AN.0.69, AN.0.39, AN.0.36, AN.0.37, AN.0.41 of explanatory notes to this Category) **Fee:** $268.80 **Benefit:** 100% = $268.80 **Extended Medicare Safety Net Cap:** $500.00
	ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES HEALTH ASSESSMENT Details of the requirements for the Aboriginal and Torres Strait Islander Peoples Health Assessment, The Aboriginal and Torres Strait Islander Peoples Health Assessment is available to: a) Children between ages of 0 and 14 years, b) Adults between the ages of 15 and 54 years, c) Older people over the age of 55 years.
715	Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent-not more than once in a 9 month period (See para AN.0.44, AN.0.46, AN.0.43, AN.0.45 of explanatory notes to this Category) **Fee:** $212.25 **Benefit:** 100% = $212.25 **Extended Medicare Safety Net Cap:** $500.00

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	1. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
	Group A15. GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
	Subgroup 1. GP Management Plans, Team Care Arrangements And Multidisciplinary Care Plans
721	Attendance by a general practitioner for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $144.25 **Benefit:** 75% = $108.20 100% = $144.25 **Extended Medicare Safety Net Cap:** $432.75

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	1. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS AND MULTIDISCIPLINARY CARE PLANS
723	Attendance by a general practitioner to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $114.30 **Benefit:** 75% = $85.75 100% = $114.30 **Extended Medicare Safety Net Cap:** $342.90
729	Contribution by a general practitioner to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $70.40 **Benefit:** 100% = $70.40 **Extended Medicare Safety Net Cap:** $211.20
731	Contribution by a general practitioner to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 apply) (See para AN.0.47 of explanatory notes to this Category) **Fee:** $70.40 **Benefit:** 100% = $70.40 **Extended Medicare Safety Net Cap:** $211.20
732	Attendance by a general practitioner to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies (See para AN.0.47 of explanatory notes to this Category) **Fee:** $72.05 **Benefit:** 75% = $54.05 100% = $72.05 **Extended Medicare Safety Net Cap:** $216.15

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS	2. CASE CONFERENCES
	Group A15. GP Management Plans, Team Care Arrangements, Multidisciplinary Care Plans
	Subgroup 2. Case Conferences
735	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service

	associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $70.65 **Benefit:** 75% = $53.00 100% = $70.65 **Extended Medicare Safety Net Cap:** $211.95
739	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $120.95 **Benefit:** 75% = $90.75 100% = $120.95 **Extended Medicare Safety Net Cap:** $362.85
743	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $201.65 **Benefit:** 75% = $151.25 100% = $201.65 **Extended Medicare Safety Net Cap:** $500.00
747	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $51.90 **Benefit:** 75% = $38.95 100% = $51.90 **Extended Medicare Safety Net Cap:** $155.70
750	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or

	(b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply) (See para AN.0.49 of explanatory notes to this Category) **Fee:** $89.00 **Benefit:** 75% = $66.75 100% = $89.00 **Extended Medicare Safety Net Cap:** $267.00
758	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply) **Fee:** $148.20 **Benefit:** 75% = $111.15 100% = $148.20 **Extended Medicare Safety Net Cap:** $444.60
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
825	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $101.40 **Benefit:** 75% = $76.05 85% = $86.20

	Extended Medicare Safety Net Cap: $304.20
826	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10
828	Attendance by a consultant physician in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $222.05 **Benefit:** 75% = $166.55 85% = $188.75 **Extended Medicare Safety Net Cap:** $500.00
830	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
832	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
834	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
835	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $101.40 **Benefit:** 75% = $76.05 85% = $86.20 **Extended Medicare Safety Net Cap:** $304.20
837	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category)

	Fee: $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10
838	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.51 of explanatory notes to this Category) **Fee:** $222.05 **Benefit:** 75% = $166.55 85% = $188.75 **Extended Medicare Safety Net Cap:** $500.00
855	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
857	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
858	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.62 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
861	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
864	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
866	Attendance by a consultant physician in the practice of his or her specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes,

A15. GP MANAGEMENT PLANS, TEAM CARE ARRANGEMENTS, MULTIDISCIPLINARY CARE PLANS — 2. CASE CONFERENCES	
	with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.62 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
871	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.0.65 of explanatory notes to this Category) **Fee:** $81.50 **Benefit:** 75% = $61.15 85% = $69.30 **Extended Medicare Safety Net Cap:** $244.50
872	Attendance by a general practitioner, specialist or consultant physician as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers (See para AN.0.65 of explanatory notes to this Category) **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30 **Extended Medicare Safety Net Cap:** $113.85
880	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes-for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H) (See para AN.0.63 of explanatory notes to this Category) **Fee:** $49.40 **Benefit:** 75% = $37.05 **Extended Medicare Safety Net Cap:** $148.20

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	Group A17. Domiciliary And Residential Management Reviews
900	Participation by a general practitioner in a Domiciliary Medication Management Review (DMMR) for a patient living in a community setting, in which the general practitioner, with the patient's consent: (a) assesses the patient as: (i) having a chronic medical condition or a complex medication regimen; and (ii) not having their therapeutic goals met; and (b) following that assessment: (i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and (ii) provides relevant clinical information required for the DMMR; and (c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and

A17. DOMICILIARY AND RESIDENTIAL MANAGEMENT REVIEWS	
	(d) develops a written medication management plan following discussion with the patient; and (e) provides the written medication management plan to a community pharmacy chosen by the patient For any particular patient—applicable not more than once in each 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (See para AN.0.52 of explanatory notes to this Category) **Fee:** $154.80 **Benefit:** 100% = $154.80 **Extended Medicare Safety Net Cap:** $464.40
903	Participation by a general practitioner in a residential medication management review (RMMR) for a patient who is a permanent resident of a residential aged care facility-other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR (See para AN.0.52 of explanatory notes to this Category) **Fee:** $106.00 **Benefit:** 100% = $106.00 **Extended Medicare Safety Net Cap:** $318.00

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	Group A18. General Practitioner Attendance Associated With Pip Incentive Payments
	Subgroup 1. Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Person
	LEVEL A Professional attendance involving taking a short patient history and, if required, limited examination and management **and** at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2497	Professional attendance at consulting rooms by a general practitioner: (a) involving taking a short patient history and, if required, limited examination and management; and (b) at which a specimen for a cervical screening service is collected from the patient; if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Fee:** $16.95 **Benefit:** 100% = $16.95 **Extended Medicare Safety Net Cap:** $50.85
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation

	and at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2501	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
2503	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years. (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 2501, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2501 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: f) taking a detailed patient history; g) performing a clinical examination; h) arranging any necessary investigation; i) implementing a management plan; j) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation

	and at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2504	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2506	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 2504, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2504 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care;

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	in relation to 1 or more health-related issues, with appropriate documentation **and** at which a cervical screening test is taken from a person at least 24 years and 9 months of age but is less than 75 years of age, who has not had a cervical screening test in the last 4 years.
2507	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2509	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 2507, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2507 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	2. COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	Group A18. General Practitioner Attendance Associated With Pip Incentive Payments

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	2. COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	Subgroup 2. Completion Of A Cycle Of Care For Patients With Established Diabetes Mellitus
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2517	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
2518	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Derived Fee:** The fee for item 2517, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	**2. COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS**
	Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2521	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2522	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Derived Fee:** The fee for item 2521, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history;

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	2. COMPLETION OF A CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus.
2525	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.9, AN.0.54 of explanatory notes to this Category) **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2526	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of a cycle of care for a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** The fee for item 2525, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	Group A18. General Practitioner Attendance Associated With Pip Incentive Payments
	Subgroup 3. Completion Of The Asthma Cycle Of Care

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
2546	Professional attendance by a general practitioner at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55, AN.0.9 of explanatory notes to this Category) **Fee:** $37.05 **Benefit:** 100% = $37.05 **Extended Medicare Safety Net Cap:** $111.15
2547	Professional attendance by a general practitioner at a place other than consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 2546, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination;

	c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation AND which completes the minimum requirements of the Asthma Cycle of Care.
2552	Professional attendance by a general practitioner at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55, AN.0.9 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2553	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** The fee for item 2552, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2552 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation

A18. GENERAL PRACTITIONER ATTENDANCE ASSOCIATED WITH PIP INCENTIVE PAYMENTS	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	AND which completes the minimum requirements of the Asthma Cycle of Care.
2558	Professional attendance by a general practitioner at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55, AN.0.9 of explanatory notes to this Category) **Fee:** $105.55 **Benefit:** 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2559	Professional attendance by a general practitioner at a place other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, and that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 2558, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2558 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	Group A19. Other Non-Referred Attendances Associated With Pip Incentive Payments To Which No Other Item Applies
	Subgroup 1. Taking Of A Cervical Smear From An Unscreened Or Significantly Underscreened Person
2598	Professional attendance at consulting rooms of less than 5 minutes in duration by a medical practitioner who practices in general practice (other than a general practitioner) at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
	(See para AN.0.53 of explanatory notes to this Category) **Fee:** $11.00 **Benefit:** 100% = $11.00 **Extended Medicare Safety Net Cap:** $33.00
2600	Professional attendance at consulting rooms of more than 5, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2603	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2606	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2610	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2613	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	1. TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED PERSON
2616	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), at which a specimen for a cervical screening service is collected from the patient, if the patient is at least 24 years and 9 months of age but is less than 75 years of age and has not been provided with a cervical screening service or a cervical smear service in the last 4 years (See para AN.0.53 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	2. COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	Group A19. Other Non-Referred Attendances Associated With Pip Incentive Payments To Which No Other Item Applies
	Subgroup 2. Completion Of An Annual Cycle Of Care For Patients With Established Diabetes Mellitus
2620	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2622	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2624	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Fee:** $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2631	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	2. COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH ESTABLISHED DIABETES MELLITUS
	lesser amount
2633	Professional attendance at a place other than consulting rooms of more than 25 minutes but not more than 45 minutes, in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2635	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements for a cycle of care of a patient with established diabetes mellitus (See para AN.0.54 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	Group A19. Other Non-Referred Attendances Associated With Pip Incentive Payments To Which No Other Item Applies
	Subgroup 3. Completion Of The Asthma Cycle Of Care
2664	Professional attendance at consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
2666	Professional attendance at consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Fee:** $38.00 **Benefit:** 100% = $38.00 **Extended Medicare Safety Net Cap:** $114.00
2668	Professional attendance at consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category)

A19. OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES	3. COMPLETION OF THE ASTHMA CYCLE OF CARE
	Fee: $61.00 **Benefit:** 100% = $61.00 **Extended Medicare Safety Net Cap:** $183.00
2673	Professional attendance at a place other than consulting rooms of more than 5 minutes, but not more than 25 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** An amount equal to $16.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $16.00 plus $0.70 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2675	Professional attendance at a place other than consulting rooms of more than 25 minutes, but not more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** An amount equal to $35.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $35.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2677	Professional attendance at a place other than consulting rooms of more than 45 minutes in duration by a medical practitioner who practises in general practice (other than a general practitioner), that completes the minimum requirements of the Asthma Cycle of Care (See para AN.0.55 of explanatory notes to this Category) **Derived Fee:** An amount equal to $57.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $57.50 plus $0.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A20. GP MENTAL HEALTH TREATMENT	**1. GP MENTAL HEALTH TREATMENT PLANS**
	Group A20. GP Mental Health Treatment
	Subgroup 1. GP Mental Health Treatment Plans
2700	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 75% = $53.80 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2701	Professional attendance by a general practitioner (including a general practitioner who has not undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $105.55 **Benefit:** 75% = $79.20 100% = $105.55 **Extended Medicare Safety Net Cap:** $316.65
2712	Professional attendance by a general practitioner to review a GP mental health treatment plan which he or she, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and

A20. GP MENTAL HEALTH TREATMENT	1. GP MENTAL HEALTH TREATMENT PLANS
	Management Plan (See para AN.0.56 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 75% = $53.80 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2713	Professional attendance by a general practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation (See para AN.0.56 of explanatory notes to this Category) **Fee:** $71.70 **Benefit:** 100% = $71.70 **Extended Medicare Safety Net Cap:** $215.10
2715	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $91.05 **Benefit:** 75% = $68.30 100% = $91.05 **Extended Medicare Safety Net Cap:** $273.15
2717	Professional attendance by a general practitioner (including a general practitioner who has undertaken mental health skills training) of at least 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient (See para AN.0.56 of explanatory notes to this Category) **Fee:** $134.10 **Benefit:** 75% = $100.60 100% = $134.10 **Extended Medicare Safety Net Cap:** $402.30
A20. GP MENTAL HEALTH TREATMENT	**2. FOCUSSED PSYCHOLOGICAL STRATEGIES**
	Group A20. GP Mental Health Treatment
	Subgroup 2. Focussed Psychological Strategies
2721	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Fee:** $92.75 **Benefit:** 100% = $92.75 **Extended Medicare Safety Net Cap:** $278.25
2723	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Derived Fee:** The fee for item 2721, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2725	Professional attendance at consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes (See para AN.0.57 of explanatory notes to this Category)

A20. GP MENTAL HEALTH TREATMENT	2. FOCUSSED PSYCHOLOGICAL STRATEGIES
	Fee: $132.75 **Benefit:** 100% = $132.75 **Extended Medicare Safety Net Cap:** $398.25
2727	Professional attendance at a place other than consulting rooms by a general practitioner, for providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes (See para AN.0.57 of explanatory notes to this Category) **Derived Fee:** The fee for item 2725, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
New 2729	Professional attendance at consulting rooms by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner. (See para AN.0.57 of explanatory notes to this Category) **Fee:** $92.75 **Benefit:** 100% = $92.75 **Extended Medicare Safety Net Cap:** $278.25
New 2731	Professional attendance at consulting rooms by a general practitioner, for the purpose of providing focussed psychological strategies for assessed mental disorders by a general practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient is located within a telehealth eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner (See para AN.0.57 of explanatory notes to this Category) **Fee:** $132.75 **Benefit:** 100% = $132.75 **Extended Medicare Safety Net Cap:** $398.25

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. CONSULTATIONS
	Group A21. Medical Practitioner (Emergency Physician) Attendances To Which No Other Item Applies
	Subgroup 1. Consultations
501	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for the unscheduled evaluation and

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. CONSULTATIONS
	management of a patient, involving straightforward medical decision making that requires: (a) taking a problem focussed history; and (b) limited examination; and (c) diagnosis; and (d) initiation of appropriate treatment interventions (See para AN.0.60 of explanatory notes to this Category) **Fee:** $34.70 **Benefit:** 75% = $26.05 85% = $29.50 **Extended Medicare Safety Net Cap:** $104.10
503	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of low complexity that requires: (a) taking an expanded problem focussed history; and (b) expanded examination of one or more systems; and (c) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (d) initiation of appropriate treatment interventions (See para AN.0.60 of explanatory notes to this Category) **Fee:** $58.65 **Benefit:** 75% = $44.00 85% = $49.90 **Extended Medicare Safety Net Cap:** $175.95
507	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of moderate complexity that requires: (a) taking an expanded problem focussed history; and (b) expanded examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions (See para AN.0.60 of explanatory notes to this Category) **Fee:** $98.50 **Benefit:** 75% = $73.90 85% = $83.75 **Extended Medicare Safety Net Cap:** $295.50
511	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of moderate complexity that requires: (a) taking a detailed history; and (b) detailed examination of one or more systems; and

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	1. CONSULTATIONS
	(c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions; and (f) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent (See para AN.0.60 of explanatory notes to this Category) **Fee:** $139.35 **Benefit:** 75% = $104.55 85% = $118.45 **Extended Medicare Safety Net Cap:** $418.05
515	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for the unscheduled evaluation and management of a patient, involving medical decision making of high complexity that requires: (a) taking a comprehensive history; and (b) comprehensive examination of one or more systems; and (c) ordering and evaluation of appropriate investigations; and (d) formulation and documentation of a diagnosis and management plan in relation to one or more problems; and (e) initiation of appropriate treatment interventions; and (f) liaison with relevant health care professionals and discussion with, as appropriate, the patient or the patient's relatives or agent (See para AN.0.60 of explanatory notes to this Category) **Fee:** $215.80 **Benefit:** 75% = $161.85 85% = $183.45 **Extended Medicare Safety Net Cap:** $500.00

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	Group A21. Medical Practitioner (Emergency Physician) Attendances To Which No Other Item Applies
	Subgroup 2. Prolonged Professional Attendances To Which No Other Group Applies
519	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 30 minutes but less than 1 hour (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $148.40 **Benefit:** 75% = $111.30 85% = $126.15 **Extended Medicare Safety Net Cap:** $445.20
520	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 1 hour but less than 2 hours (before the patient's admission to an in-patient

A21. MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	2. PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES
	hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $285.05 **Benefit:** 75% = $213.80 85% = $242.30 **Extended Medicare Safety Net Cap:** $500.00
530	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 2 hours but less than 3 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $467.20 **Benefit:** 75% = $350.40 85% = $397.15 **Extended Medicare Safety Net Cap:** $500.00
532	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 3 hours but less than 4 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $649.35 **Benefit:** 75% = $487.05 85% = $565.95 **Extended Medicare Safety Net Cap:** $500.00
534	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 4 hours but less than 5 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $831.65 **Benefit:** 75% = $623.75 85% = $748.25 **Extended Medicare Safety Net Cap:** $500.00
536	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of his or her specialty of emergency medicine-attendance for a total period (whether or not continuous) of at least 5 hours (before the patient's admission to an in-patient hospital bed) for emergency evaluation of a critically ill patient with an immediately life threatening problem (See para AN.0.61 of explanatory notes to this Category) **Fee:** $922.75 **Benefit:** 75% = $692.10 85% = $839.35 **Extended Medicare Safety Net Cap:** $500.00

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A22. General Practitioner After-Hours Attendances To Which No Other Item Applies
	LEVEL A Professional attendance by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.
5000	Professional attendance at consulting rooms (other than a service to which another item applies) by a

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-each attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $29.00 **Benefit:** 100% = $29.00 **Extended Medicare Safety Net Cap:** $87.00
5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies) that requires a short patient history and, if necessary, limited examination and management-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.11, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is accommodated in a residential aged care facility (other than accommodation in a self-contained unit) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5000, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5000 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL B Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting less than 20 minutes, including any of the following that are clinically relevant: a) taking a patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $49.00 **Benefit:** 100% = $49.00 **Extended Medicare Safety Net Cap:** $147.00
5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.11, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5028	Professional attendance by a general practitioner (other than a service to which another item in the table applies), at a residential aged care facility to residents of the facility, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5020, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5020 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL C Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant: a) taking a detailed patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
5040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $83.95 **Benefit:** 100% = $83.95 **Extended Medicare Safety Net Cap:** $251.85
5043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient (See para AN.0.19, AN.0.11, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5049	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5040, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5040 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	LEVEL D Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 40 minutes, including any of the following that are clinically relevant: a) taking an extensive patient history; b) performing a clinical examination; c) arranging any necessary investigation; d) implementing a management plan; e) providing appropriate preventive health care; in relation to 1 or more health-related issues, with appropriate documentation.
5060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-each attendance (See para AN.0.19, AN.0.9 of explanatory notes to this Category) **Fee:** $117.75 **Benefit:** 100% = $117.75 **Extended Medicare Safety Net Cap:** $353.25
5063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients on one occasion-each patient

A22. GENERAL PRACTITIONER AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(See para AN.0.19, AN.0.11, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5067	Professional attendance by a general practitioner at a residential aged care facility to residents of the facility (other than a service to which another item in the table applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.19, AN.0.15, AN.0.9 of explanatory notes to this Category) **Derived Fee:** The fee for item 5060, plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 5060 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A23. Other Non-Referred After-Hours Attendances To Which No Other Item Applies
	CONSULTATION AT CONSULTING ROOMS Professional attendance by a medical practitioner (other than a general practitioner) at consulting rooms
5200	Professional attendance at consulting rooms of not more than 5 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $21.00 **Benefit:** 100% = $21.00 **Extended Medicare Safety Net Cap:** $63.00
5203	Professional attendance at consulting rooms of more than 5 minutes in duration but not more than 25 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $31.00 **Benefit:** 100% = $31.00 **Extended Medicare Safety Net Cap:** $93.00
5207	Professional attendance at consulting rooms of more than 25 minutes in duration but not more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $48.00 **Benefit:** 100% = $48.00

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Extended Medicare Safety Net Cap: $144.00
5208	Professional attendance at consulting rooms of more than 45 minutes in duration (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)-each attendance **Fee:** $71.00 **Benefit:** 100% = $71.00 **Extended Medicare Safety Net Cap:** $213.00
	CONSULTATION AT A PLACE OTHER THAN CONSULTING ROOMS, HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY Professional attendance by a medical practitioner (other than a general practitioner) on 1 or more patients on 1 occasion at a place other than consulting rooms, a hospital or residential aged care facility.
5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting not more than 5 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $18.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 5 minutes, but not more than 25 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $26.00, plus $17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 25 minutes, but not more than 45 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $45.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in the table applies), lasting more than 45 minutes-an attendance on one or more patients on one occasion-each patient (See para AN.0.11 of explanatory notes to this Category) **Derived Fee:** An amount equal to $67.50, plus $15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $.70 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY Professional attendance on 1 or more patients on 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding

A23. OTHER NON-REFERRED AFTER-HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	accommodation in a self-contained unit) on 1 occasion – each patient
5260	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of not more than 5 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $18.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $18.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5263	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 5 minutes in duration but not more than 25 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $26.00, plus $31.55 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $26.00 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5265	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 25 minutes in duration but not more than 45 minutes by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $45.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $45.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
5267	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex if the patient is accommodated in the residential aged care facility (other than accommodation in a self-contained unit) of more than 45 minutes in duration by a medical practitioner (other than a general practitioner)-an attendance on one or more patients at one residential aged care facility on one occasion-each patient (See para AN.0.15 of explanatory notes to this Category) **Derived Fee:** An amount equal to $67.50, plus $27.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to $67.50 plus $1.25 per patient **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A24. PAIN AND PALLIATIVE MEDICINE	**1. PAIN MEDICINE ATTENDANCES**
	Group A24. Pain And Palliative Medicine

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	Subgroup 1. Pain Medicine Attendances
2799	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) 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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $114.90 **Benefit:** 85% = $97.70 **Extended Medicare Safety Net Cap:** $344.70
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20 **Extended Medicare Safety Net Cap:** $459.45
2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner-each attendance (other than a service to which item 2814 applies) after the first in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20 **Extended Medicare Safety Net Cap:** $229.95
2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
2820	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of pain medicine if:

A24. PAIN AND PALLIATIVE MEDICINE	1. PAIN MEDICINE ATTENDANCES
	(a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 2801 lasting more than 10 minutes; or (ii) provided with item 2806 or 2814; 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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 2801, 2806 or 2814. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $185.85 **Benefit:** 85% = $158.00 **Extended Medicare Safety Net Cap:** $500.00
2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner-each attendance (other than a service to which item 2840 applies) after the first in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $112.40 **Benefit:** 85% = $95.55 **Extended Medicare Safety Net Cap:** $337.20
2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine following referral of the patient to him or her by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $80.95 **Benefit:** 85% = $68.85 **Extended Medicare Safety Net Cap:** $242.85
A24. PAIN AND PALLIATIVE MEDICINE	**2. PAIN MEDICINE CASE CONFERENCES**

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
	Group A24. Pain And Palliative Medicine
	Subgroup 2. Pain Medicine Case Conferences
2946	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
2949	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
2954	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
2958	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $101.40 **Benefit:** 75% = $76.05 85% = $86.20 **Extended Medicare Safety Net Cap:** $304.20
2972	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10
2974	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $222.05 **Benefit:** 75% = $166.55 85% = $188.75 **Extended Medicare Safety Net Cap:** $500.00
2978	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60

A24. PAIN AND PALLIATIVE MEDICINE	2. PAIN MEDICINE CASE CONFERENCES
2984	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
2988	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
2992	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $101.40 **Benefit:** 75% = $76.05 85% = $86.20 **Extended Medicare Safety Net Cap:** $304.20
2996	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10
3000	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $222.05 **Benefit:** 75% = $166.55 85% = $188.75 **Extended Medicare Safety Net Cap:** $500.00

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
	Group A24. Pain And Palliative Medicine
	Subgroup 3. Palliative Medicine Attendances
3003	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) 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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $114.90 **Benefit:** 85% = $97.70 **Extended Medicare Safety Net Cap:** $344.70
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20 **Extended Medicare Safety Net Cap:** $459.45
3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner-each attendance (other than a service to which item 3014 applies) after the first in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20 **Extended Medicare Safety Net Cap:** $229.95
3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58, AN.0.70 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
3015	Professional attendance on a patient by a specialist or consultant physician practising in his or her specialty of palliative medicine if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 3005 lasting more than 10 minutes; or (ii) provided with item 3010 or 3014; and (c) the patient is not an admitted patient; and (d) the patient:

A24. PAIN AND PALLIATIVE MEDICINE	3. PALLIATIVE MEDICINE ATTENDANCES
	(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 physician; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 3005, 3010 or 3014. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $185.85 **Benefit:** 85% = $158.00 **Extended Medicare Safety Net Cap:** $500.00
3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner-each attendance (other than a service to which item 3028 applies) after the first in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $112.40 **Benefit:** 85% = $95.55 **Extended Medicare Safety Net Cap:** $337.20
3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine following referral of the patient to him or her by a referring practitioner-each minor attendance after the first attendance in a single course of treatment (See para AN.0.58 of explanatory notes to this Category) **Fee:** $80.95 **Benefit:** 85% = $68.85 **Extended Medicare Safety Net Cap:** $242.85
A24. PAIN AND PALLIATIVE MEDICINE	**4. PALLIATIVE MEDICINE CASE CONFERENCES**
	Group A24. Pain And Palliative Medicine
	Subgroup 4. Palliative Medicine Case Conferences
3032	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
3040	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative

	medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
3044	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
3051	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $101.40 **Benefit:** 75% = $76.05 85% = $86.20 **Extended Medicare Safety Net Cap:** $304.20
3055	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines (See para AN.0.58 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10
3062	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes (See para AN.0.58 of explanatory notes to this Category) **Fee:** $222.05 **Benefit:** 75% = $166.55 85% = $188.75 **Extended Medicare Safety Net Cap:** $500.00
3069	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $141.20 **Benefit:** 75% = $105.90 85% = $120.05 **Extended Medicare Safety Net Cap:** $423.60
3074	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $211.85 **Benefit:** 75% = $158.90 85% = $180.10 **Extended Medicare Safety Net Cap:** $500.00
3078	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)

A24. PAIN AND PALLIATIVE MEDICINE	4. PALLIATIVE MEDICINE CASE CONFERENCES
	(See para AN.0.58 of explanatory notes to this Category) **Fee:** $282.30 **Benefit:** 75% = $211.75 85% = $240.00 **Extended Medicare Safety Net Cap:** $500.00
3083	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $101.40 **Benefit:** 75% = $76.05 85% = $86.20 **Extended Medicare Safety Net Cap:** $304.20
3088	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $161.70 **Benefit:** 75% = $121.30 85% = $137.45 **Extended Medicare Safety Net Cap:** $485.10
3093	Attendance by a specialist, or consultant physician, in the practice of his or her specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H) (See para AN.0.58 of explanatory notes to this Category) **Fee:** $222.05 **Benefit:** 75% = $166.55 85% = $188.75 **Extended Medicare Safety Net Cap:** $500.00
A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	Group A26. Neurosurgery Attendances To Which No Other Item Applies
6004	Initial professional attendance of 10 minutes or less in duration on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) 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; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and

A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(d) no other initial consultation has taken place for a single course of treatment (See para AN.0.68 of explanatory notes to this Category) **Fee:** $98.65 **Benefit:** 85% = $83.90 **Extended Medicare Safety Net Cap:** $295.95
6007	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her-an attendance (other than a second or subsequent attendance in a single course of treatment) at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $131.55 **Benefit:** 75% = $98.70 85% = $111.85 **Extended Medicare Safety Net Cap:** $394.65
6009	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her-a minor attendance after the first in a single course of treatment at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15 **Extended Medicare Safety Net Cap:** $130.95
6011	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her-an attendance after the first in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 15 minutes in duration but not more than 30 minutes in duration at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $86.85 **Benefit:** 75% = $65.15 85% = $73.85 **Extended Medicare Safety Net Cap:** $260.55
6013	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her-an attendance after the first in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 30 minutes in duration but not more than 45 minutes in duration at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $120.30 **Benefit:** 75% = $90.25 85% = $102.30 **Extended Medicare Safety Net Cap:** $360.90
6015	Professional attendance by a specialist in the practice of neurosurgery following referral of the patient to him or her-an attendance after the first in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and of more than 45 minutes in duration at consulting rooms or hospital (See para AN.0.64 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20 **Extended Medicare Safety Net Cap:** $459.45
6016	Professional attendance on a patient by a specialist practising in his or her specialty of neurosurgery if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6007 lasting more than 10 minutes; or (ii) provided with item 6009, 6011, 6013 or 6015; and

A26. NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	(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; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 6007, 6009, 6011, 6013 or 6015. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
A27. PREGNANCY SUPPORT COUNSELLING	
	Group A27. Pregnancy Support Counselling
4001	Professional attendance of at least 20 minutes in duration at consulting rooms by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act. (See para AN.0.66 of explanatory notes to this Category) **Fee:** $76.60 **Benefit:** 100% = $76.60 **Extended Medicare Safety Net Cap:** $229.80
A28. GERIATRIC MEDICINE	
	Group A28. Geriatric Medicine
141	Professional attendance of more than 60 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and

A28. GERIATRIC MEDICINE	
	(c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the *assessment*); and (ii) the patient's various health problems and care needs are identified and prioritised (the *formulation*); and (iii) a detailed management plan is prepared (the *management plan*) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months (See para AN.0.26 of explanatory notes to this Category) **Fee:** $459.45 **Benefit:** 75% = $344.60 85% = $390.55 **Extended Medicare Safety Net Cap:** $500.00
143	Professional attendance of more than 30 minutes in duration at consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or item 147 applies has not been provided to the patient in the

A28. GERIATRIC MEDICINE	
	preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review (See para AN.0.26 of explanatory notes to this Category) **Fee:** $287.20 **Benefit:** 75% = $215.40 85% = $244.15 **Extended Medicare Safety Net Cap:** $500.00
145	Professional attendance of more than 60 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine, if: (a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and (b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and (c) during the attendance: (i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail utilising appropriately validated assessment tools if indicated (the *assessment*); and (ii) the patient's various health problems and care needs are identified and prioritised (the *formulation*); and (iii) a detailed management plan is prepared (the *management plan*) setting out: (A) the prioritised list of health problems and care needs; and (B) short and longer term management goals; and (C) recommended actions or intervention strategies, to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient, the patient's family and any carers; and (iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and (v) the management plan is communicated in writing to the referring practitioner; and (d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months (See para AN.0.26 of explanatory notes to this Category) **Fee:** $557.10 **Benefit:** 85% = $473.70 **Extended Medicare Safety Net Cap:** $500.00
147	Professional attendance of more than 30 minutes in duration at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of his or her specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if: (a) the review is initiated by the referring medical practitioner practising in general practice or a

A28. GERIATRIC MEDICINE	
	participating nurse practitioner; and (b) during the attendance: (i) the patient's health status is reassessed; and (ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and (iii) the revised management plan is explained to the patient and (if appropriate) the patient's family and any carers and communicated in writing to the referring practitioner; and (c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and (d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and (e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient's clinical condition or care circumstances that requires a further review (See para AN.0.26 of explanatory notes to this Category) **Fee:** $348.25 **Benefit:** 85% = $296.05 **Extended Medicare Safety Net Cap:** $500.00
149	Professional attendance on a patient by a consultant physician or specialist practising in his or her specialty of geriatric medicine if: (a) the attendance is by video conference; and (b) item 141 or 143 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 physician or specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.0.68 of explanatory notes to this Category) **Derived Fee:** 50% of the fee for item 141 or 143. Benefit: 85% of the derived fee **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A29. EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY	
	Group A29. Early Intervention Services For Children With Autism, Pervasive Developmental Disorder Or Disability
135	Professional attendance of at least 45 minutes in duration at consulting rooms or hospital, by a consultant physician in the practice of his or her specialty of paediatrics, following referral of the patient to the consultant by a referring practitioner, for assessment, diagnosis and preparation of a treatment and management plan for a patient aged under 13 years with autism or another pervasive developmental disorder, if the consultant paediatrician does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medical recommendations; (c) provides a copy of the treatment and management plan to: (i) the referring practitioner; and (ii) one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 137, 139 or 289) (See para AN.0.24 of explanatory notes to this Category) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70 **Extended Medicare Safety Net Cap:** $500.00
137	Professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a referring practitioner, if the specialist or consultant physician does the following: (a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate) (b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary.

A29. EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY	
	(c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate). Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289. (See para AN.0.25 of explanatory notes to this Category) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70 **Extended Medicare Safety Net Cap:** $500.00
139	Professional attendance of at least 45 minutes in duration at consulting rooms only, by a general practitioner (not including a specialist or consultant physician) for assessment, diagnosis and preparation of a treatment and management plan for a patient under 13 years with an eligible disability if the general practitioner does all of the following: (a) undertakes a comprehensive assessment and makes a diagnosis (if appropriate, using information provided by an eligible allied health provider); (b) develops a treatment and management plan, which must include the following: (i) an assessment and diagnosis of the patient's condition; (ii) a risk assessment; (iii) treatment options and decisions; (iv) if necessary-medication recommendations; (c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient; (other than attendance on a patient for whom payment has previously been made under this item or item 135, 137 or 289) (See para AN.0.25 of explanatory notes to this Category) **Fee:** $134.50 **Benefit:** 100% = $134.50 **Extended Medicare Safety Net Cap:** $403.50

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	1. TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 1. Telehealth Attendance At Consulting Rooms, Home Visits Or Other Institutions
2100	Professional attendance at consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and

	(c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $22.90 **Benefit:** 100% = $22.90 **Extended Medicare Safety Net Cap:** $68.70
2122	Professional attendance not in consulting rooms of at least 5 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2100 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2126	Professional attendance at consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $49.95 **Benefit:** 100% = $49.95 **Extended Medicare Safety Net Cap:** $149.85
2137	Professional attendance not in consulting rooms of less than 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2126 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2143	Professional attendance at consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner who provides clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (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 physician

	mentioned in paragraph (a); or (ii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service: for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $96.85 **Benefit:** 100% = $96.85 **Extended Medicare Safety Net Cap:** $290.55
2147	Professional attendance not in consulting rooms of at least 20 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2143 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2195	Professional attendance at consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) either: (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 physician mentioned in paragraph (a); or (ii) is a patient of:

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	1. TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
	(A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies (See para AN.0.67 of explanatory notes to this Category) **Fee:** $142.50 **Benefit:** 100% = $142.50 **Extended Medicare Safety Net Cap:** $427.50
2199	Professional attendance not in consulting rooms of at least 40 minutes in duration (whether or not continuous) by a medical practitioner providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is not an admitted patient; and (c) is not a care recipient in a residential care service; and (d) is located both: (i) within a telehealth eligible area; and (ii) at the time of the attendance-at least 15 kms by road from the specialist or physician mentioned in paragraph (a); for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2195 plus $25.95 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $2.00 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	2. TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 2. Telehealth Attendance At A Residential Aged Care Facility
2125	Professional attendance of at least 5 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2100 plus $46.70 divided by the number of patients seen, up to a maximum of six

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	2. TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
	patients. For seven or more patients - the fee for item 2100 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2138	Professional attendance of less than 20 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2126 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2179	Professional attendance of at least 20 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2143 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount
2220	Professional attendance of at least 40 minutes in duration (whether or not continuous) by a general practitioner, specialist or consultant physician providing clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist or consultant physician; and (b) is a care recipient in a residential care service; and (c) is not a resident of a self-contained unit; for an attendance on one or more patients at one place on one occasion-each patient (See para AN.0.67 of explanatory notes to this Category) **Derived Fee:** The fee for item 2195 plus $46.70 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $3.30 per patient. **Extended Medicare Safety Net Cap:** 300% of the Derived fee for this item, or $500.00, whichever is the lesser amount

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	3. MENTAL HEALTH AND WELL-BEING VIDEO CONFERENCING CONSULTATION
	Group A30. Medical Practitioner (Including A General Practitioner, Specialist Or Consultant Physician) Telehealth Attendances
	Subgroup 3. Mental Health and Well-being Video Conferencing Consultation
New 2121	Professional attendance at consulting rooms by a general practitioner, lasting less than 20 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the general practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner; and (e) the patient has an existing relationship with the general practitioner. (See para AN.30.1 of explanatory notes to this Category) **Fee:** $44.20 **Benefit:** 85% = $37.60 **Extended Medicare Safety Net Cap:** $132.60
New 2150	Professional attendance at consulting rooms by a general practitioner, lasting at least 20 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the general practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner; and (e) the patient has an existing relationship with the general practitioner. (See para AN.30.1 of explanatory notes to this Category) **Fee:** $85.60 **Benefit:** 85% = $72.80 **Extended Medicare Safety Net Cap:** $256.80
New 2196	Professional attendance at consulting rooms by a general practitioner, lasting at least 40 minutes, for providing mental health services to a patient with mental health issues, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient and the general practitioner are located within a drought affected eligible area; and (d) the patient is, at the time of the attendance, at least 15 kilometres by road from the general practitioner; and (e) the patient has an existing relationship with the general practitioner. (See para AN.30.1 of explanatory notes to this Category) **Fee:** $126.05 **Benefit:** 85% = $107.15

A30. MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES	**3. MENTAL HEALTH AND WELL-BEING VIDEO CONFERENCING CONSULTATION**
	Extended Medicare Safety Net Cap: $378.15
A31. ADDICTION MEDICINE	**1. ADDICTION MEDICINE ATTENDANCES**
	Group A31. Addiction Medicine
	Subgroup 1. Addiction Medicine Attendances
6018	Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20
6019	Professional attendance by an addiction medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment (See para AN.0.70 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20
6023	Professional attendance by an addiction medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	Professional attendance by an addiction medicine specialist in the practice of his or her specialty of at least 20 minutes, after the first attendance in a single course of treatment, for a review of a patient with at least 2 morbidities if: (a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) item 6023 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period
6024	**Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
	Initial professional attendance of 10 minutes or less, on a patient by an addiction medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or
6025	

A31. ADDICTION MEDICINE	1. ADDICTION MEDICINE ATTENDANCES
	(B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and (d) no other initial consultation has taken place for a single course of treatment **Fee:** $114.90 **Benefit:** 85% = $97.70
6026	Professional attendance on a patient by an addiction medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6018 or 6019 and lasting more than 10 minutes; or (ii) provided with item 6023 or 6024; 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 km by road from the addiction medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies **Derived Fee:** 50% of the fee for item 6018, 6019, 6023, or 6024 Benefit: 85% of the derived fee
A31. ADDICTION MEDICINE	**2. GROUP THERAPY**
	Group A31. Addiction Medicine
	Subgroup 2. Group Therapy
6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of his or her specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner-for each patient **Fee:** $50.05 **Benefit:** 75% = $37.55 85% = $42.55
A31. ADDICTION MEDICINE	**3. ADDICTION MEDICINE CASE CONFERENCES**
	Group A31. Addiction Medicine
	Subgroup 3. Addiction Medicine Case Conferences

A31. ADDICTION MEDICINE	3. ADDICTION MEDICINE CASE CONFERENCES
6029	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85
6031	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20
6032	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
6034	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20
6035	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
6037	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $61.30 **Benefit:** 75% = $46.00 85% = $52.15
6038	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $92.00 **Benefit:** 75% = $69.00 85% = $78.20
6042	Attendance by an addiction medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	Group A32. Sexual Health Medicine
	Subgroup 1. Sexual Health Medicine Attendances
6051	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20
6052	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment (See para AN.0.70 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20
6057	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to him or her by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $227.70
6058	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty of at least 20 minutes, after the first attendance in a single course of treatment, for a review of a patient with at least 2 morbidities if:

	(a) a review is undertaken that covers: (i) review of initial presenting problems and results of diagnostic investigations; and (ii) review of responses to treatment and medication plans initiated at time of initial consultation; and (iii) comprehensive multi or detailed single organ system assessment; and (iv) review of original and differential diagnoses; and (b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: (i) a revised opinion on diagnosis and risk assessment; and (ii) treatment options and decisions; and (iii) revised medication recommendations; and (c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) item 6057 applied to an attendance claimed in the preceding 12 months; and (e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and (f) this item has not applied more than twice in any 12 month period **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
6059	Initial professional attendance of 10 minutes or less, on a patient by a sexual health medicine specialist in the practice of his or her specialty, if: (a) the attendance is by video conference; and (b) the patient is not an admitted patient; and (c) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance-at least 15 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19(2) of the Act applies; and

A32. SEXUAL HEALTH MEDICINE	1. SEXUAL HEALTH MEDICINE ATTENDANCES
	(d) no other initial consultation has taken place for a single course of treatment **Fee:** $114.90 **Benefit:** 85% = $97.70
	Professional attendance on a patient by a sexual health medicine specialist in the practice of his or her specialty if: (a) the attendance is by video conference; and (b) the attendance is for a service: (i) provided with item 6051 or 6052 and lasting more than 10 minutes; or (ii) provided with item 6057 or 6058; 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 km by road from the sexual health medicine specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service; for which a direction made under subsection 19 (2) of the Act applies
6060	**Derived Fee:** 50% of the fee for item 6051, 6052, 6057 or 6058 Benefit: 85% of the derived fee

A32. SEXUAL HEALTH MEDICINE	2. HOME VISITS
	Group A32. Sexual Health Medicine
	Subgroup 2. Home Visits
6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner-initial attendance in a single course of treatment **Fee:** $185.85 **Benefit:** 85% = $158.00
6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of his or her specialty following referral of the patient to him or her by a referring practitioner-each attendance after the attendance under item 6062 in a single course of treatment **Fee:** $112.40 **Benefit:** 85% = $95.55

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	Group A32. Sexual Health Medicine

	Subgroup 3. Sexual Health Medicine Case Conferences
6064	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $43.35 **Benefit:** 75% = $32.55 85% = $36.85
6065	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $76.65 **Benefit:** 75% = $57.50 85% = $65.20
6067	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
6068	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $153.15 **Benefit:** 75% = $114.90 85% = $130.20
6071	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
6072	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $61.30 **Benefit:** 75% = $46.00 85% = $52.15
6074	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $92.00 **Benefit:** 75% = $69.00 85% = $78.20
6075	Attendance by a sexual health medicine specialist in the practice of his or her specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of

A32. SEXUAL HEALTH MEDICINE	3. SEXUAL HEALTH MEDICINE CASE CONFERENCES
	at least 45 minutes, with the multidisciplinary case conference team (See para AN.0.51 of explanatory notes to this Category) **Fee:** $122.55 **Benefit:** 75% = $91.95 85% = $104.20
A33. TRANSCATHETER AORTIC VALVE IMPLANTATION CASE CONFERENCE	
	Group A33. Transcatheter Aortic Valve Implantation Case Conference
6080	Coordination of a TAVI Case Conference by a TAVI Practitioner where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than once per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $50.15 **Benefit:** 75% = $37.65 85% = $42.65
6081	Attendance at a TAVI Case Conference by a specialist or consultant physician who does not also perform the service described in item 6080 for the same case conference where the TAVI Case Conference has a duration of 10 minutes or more. (Not payable more than twice per patient in a five year period.) (See para AN.33.1, TN.8.135 of explanatory notes to this Category) **Fee:** $37.40 **Benefit:** 75% = $28.05 85% = $31.80
A34. HEALTH CARE HOMES	
	Group A34. Health Care Homes
6087	A professional attendance, including by telephone or videoconference, on a patient participating in the Health Care Homes Program by or on behalf of a medical practitioner (including a general practitioner but not including a specialist or consultant physician) or participating nurse practitioner employed or otherwise engaged by the Health Care Home trial site at which the patient is enrolled - each patient. The service must be provided to the patient for the purposes of the Health Care Homes Program and the service may be provided to the patient individually or as part of a group. (See para AN.34.1 of explanatory notes to this Category) **Fee:** $1.15 **Benefit:** 85% = $1.00

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