

Australian Government
Department of Health and Aged Care

Medicare Benefits Schedule Book

Category 2

Operating from 1 July 2023

Title: Medicare Benefits Schedule Book

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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.0.1 AskMBS Email Advice Service

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

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

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

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

AskMBS issues advisories summarising responses to frequently asked questions on specific subject areas. [AskMBS Email Advice Service](#)

GN.1.1 The Medicare Benefits Schedule - Introduction Schedules of Services

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

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

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

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

Explanatory Notes

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

GN.1.2 Medicare - an outline

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

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

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

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

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

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

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

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

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

GN.1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

- (a) No Medicare benefits will be paid for the service;
- (b) The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.
- (c) Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

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

Services Australia (SA) 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 SA 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 Services Australia to provide these services.

GN.2.5 Provider Numbers

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

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

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

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

GN.2.6 Locum tenens

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

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

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

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

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

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

GN.2.7 Overseas trained doctor

Ten year moratorium

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

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

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

GN.2.8 Contact details for Services Australia

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

Changes to Provider Contact Details

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

Medicare

GPO Box 9822

in your capital city

or

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

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

GN.3.9 Patient eligibility for Medicare

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 enrol with Services Australia 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 Services Australia, having completed an application form available from Services Australia'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

Services Australia when a placement is approved. General practitioner trainees need to apply for a provider number using the appropriate provider number application form available on Services Australia'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 Services Australia using the approved Application Form available on the Services Australia website: <https://www.servicesaustralia.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 and Aged

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 and Aged Care

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 Services Australia 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 and Aged Care, GPO Box 9848, Canberra, ACT, 2601.

Removal of vocational recognition status

A medical practitioner may at any time request Services Australia 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 Services Australia 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 Services Australia' 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 [Services Australia's Medicare website](#).

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

Further information about applying for recognition is available at the [Services Australia's Medicare website](#).

Services Australia (SA) has developed an [Health Practitioner Guideline to substantiate that a valid referral existed \(specialist or consultant physician\)](#) which is located on the SA website.

GN.5.15 Emergency Medicine

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

- (a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
- (b) suffering from suspected acute organ or system failure; or
- (c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- (d) suffering from a drug overdose, toxic substance or toxin effect; or
- (e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- (f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- (g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and

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

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

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

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

GN.6.16 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

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

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

- (i) the referring practitioner must have undertaken a professional attendance with the patient and turned their mind to the patient's need for referral and have communicated relevant information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);
- (ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
- (iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

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

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

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

- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

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

Examination by Specialist Anaesthetists

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

Who can Refer?

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

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

For Medicare benefit purposes, a referral may be made to

- (i) a recognised specialist:
 - (a) by a registered dental practitioner, where the referral arises from a dental service; or
 - (b) by a registered optometrist where the specialist is an ophthalmologist; or
 - (c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the first service given in accordance with the referral and for I pregnancy only or
 - (d) by a participating nurse practitioner to specialists and consultant physicians. A referral given by a participating nurse practitioner is valid until 12 months after the first service given in accordance with the referral.
- (ii) a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferral 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, e.g. "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 (e.g. 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 unreferral 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 Services Australia CEO, to produce to a medical practitioner who is an employee of Services Australia, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

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

Locum-tenens Arrangements

It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, e.g., 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 i.e. referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

Self Referral

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

GN.7.17 Billing procedures

The Services Australia website contains information on Medicare billing and claiming options. Please visit the [Services Australia](#) website for further information.

Bulk billing

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

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

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

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

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

GN.8.18 Provision for review of individual health professionals

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

Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude that it would be unacceptable to the general body of the members of the profession in which the practitioner was practicing when they rendered or initiated the services under review. It is

also an offence under Section 82 for a person or officer of a body corporate to knowingly, recklessly or negligently cause or permit a practitioner employed by the person to engage in such conduct.

Department monitors health practitioners' claiming patterns. Where Services Australia detects an anomaly, it may request the Director of PSR to review the practitioner's service provision. On receiving the request, the Director must decide whether to 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 reduced accordingly. Exceptional circumstances include, but are not limited to, those set out in the *Regulations*. These include:

an unusual occurrence;

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

the characteristics of the patients.

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

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

Additional Information

A PSR Committee may not make a finding of inappropriate practice unless it has given the person under review notice of its intention to review them, the reasons for its findings, and an opportunity to respond. In reaching their

decision, a PSR Committee is required to consider whether or not the practitioner has kept adequate and contemporaneous patient records (See general explanatory note G15.1 for more information on adequate and contemporaneous patient records).

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

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

- (i) a reprimand;
- (ii) counselling;
- (iii) repayment of Medicare benefits; and/or
- (iv) complete or partial disqualification from Medicare benefit arrangements for up to three years.

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

GN.8.19 Medicare Participation Review Committee

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

- (a) has been successfully prosecuted for relevant criminal offences;
- (b) has breached an Approved Pathology Practitioner undertaking;
- (c) has engaged in prohibited diagnostic imaging practices; or
- (d) has been found to have engaged in inappropriate practice under the Professional Services Review scheme and has received Final Determinations on two (or more) occasions.

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

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

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

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

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

GN.8.21 Comprehensive Management Framework for the MBS

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

GN.8.22 Medical Services Advisory Committee

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

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

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

GN.8.23 Pathology Services Table Committee

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

GN.9.25 Penalties and Liabilities

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

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

GN.10.26 Schedule fees and Medicare benefits

Medicare benefits are based on fees determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the MBS is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

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

There are presently three levels of Medicare benefit payable:

- a. 75% of the Schedule fee:
 - i. for professional services rendered to a patient as part of an episode of hospital treatment (other than services provided to public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' or the letter 'H' directly after an item number where used; or a description of the professional service and an indication the service was rendered as an episode of hospital treatment (for example, 'in hospital', 'hospital outpatient service', 'admitted' or 'in patient'). Certain services are not generally considered hospital treatments – see GN1.2;
 - ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number

where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'. Certain services are not generally considered hospital treatments – see GN1.2.

- b. 100% of the Schedule fee for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a general practitioner – see GN1.2 for exceptions.
- c. 85% of the Schedule fee, or the Schedule fee less \$93.20 (indexed annually in November), whichever is the greater, for all other professional services.

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

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

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

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

GN.10.27 Medicare Safety Nets

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

Original Medicare Safety Net:

Under the OMSN, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2023 is \$531.70. This threshold applies to all Medicare-eligible individuals and families.

Extended Medicare Safety Net:

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

In 2023, the threshold for concessional individuals and families, including families that received Family Tax Benefit Part (A), is \$770.30. The threshold for all other (non-concessional) individuals and families in 2023 is \$2,414.00.

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

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

EMSN Benefit Caps:

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

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

o If the fee charged by the doctor for Item A is \$125, the standard Medicare rebate is \$85, with an out-of-pocket cost of \$40. The EMSN benefit is calculated as $\$40 \times 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 \times 80\% = \20 . As this is less than the EMSN benefit cap, the full \$20 is paid.

GN.11.28 Services not listed in the MBS

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

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

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

GN.11.29 Ministerial Determinations

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

GN.12.30 Professional services

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

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

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

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

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

- (d) Item 15600 in Group T2 (Radiation Oncology);
- (e) All Group T3 (Therapeutic Nuclear Medicine) items;
- (f) All Group T4 (Obstetrics) items (except 16400 and 16514);
- (g) All Group T6 (Anaesthetics) items;
- (h) All Group T7 (Regional or Field Nerve Block) items;
- (i) All Group T8 (Operations) items;
- (j) All Group T9 (Assistance at Operations) items;
- (k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

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

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

GN.12.31 Services rendered on behalf of medical practitioners

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

- (a) the medical practitioner in whose name the service is being claimed;
- (b) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

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

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

Supervision from outside of Australia is not acceptable.

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

- (a) established consistent quality assurance procedures for the data acquisition; and
- (b) personally analysed the data and written the report.

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

GN.12.32 Medicare benefits and vaccinations

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

Example 1

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

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

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

Example 2

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

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

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

Example 3

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

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

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

GN.13.33 Services which do not attract Medicare benefits

Services not attracting benefits

- (a) telephone consultations (with the exception of COVID-19 telehealth services);
- (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) extracorporeal magnetic innervation.

Health Screening Services

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

- (a) multiphasic health screening;
- (b) mammography screening (except as provided for in Items 59300/59303);
- (c) testing of fitness to undergo physical training program, vocational activities or weight reduction programs;
- (d) compulsory examinations and tests to obtain a flying, commercial driving or other licence;

(e) entrance to schools and other educational facilities;

(f) for the purposes of legal proceedings;

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

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

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

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

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

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

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

(f) a medical 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 or the spouse of the person; or

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

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

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

GN.14.34 Principles of interpretation of the MBS

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

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

GN.14.35 Services attracting benefits on an attendance basis

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

GN.14.36 Consultation and procedures rendered at the one attendance

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

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

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

GN.14.37 Aggregate items

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

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

GN.14.38 Residential aged care facility

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

GN.15.39 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

clearly identify the name of the patient; and

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

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

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

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

Services Australia (SA) has developed an [Health Practitioner Guideline to substantiate that a specific treatment was performed](#) which is located on the SA website.

CATEGORY 2: DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUMMARY OF CHANGES FROM 01/07/2023

The 01/07/2023 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

Fee Amended

11000	11003	11004	11005	11009	11012	11015	11018	11021	11024	11027	11200	11204
11205	11210	11211	11215	11218	11219	11220	11221	11224	11235	11237	11240	11241
11242	11243	11244	11300	11302	11303	11304	11306	11309	11312	11315	11318	11324
11332	11340	11341	11342	11343	11345	11503	11505	11506	11507	11508	11512	11600
11602	11604	11605	11607	11610	11611	11612	11614	11615	11627	11704	11705	11707
11713	11714	11716	11717	11719	11720	11721	11723	11724	11725	11726	11727	11728
11729	11730	11731	11735	11736	11737	11800	11801	11810	11820	11823	11830	11833
11900	11912	11917	11919	12000	12001	12002	12003	12004	12005	12012	12017	12021
12022	12024	12200	12201	12203	12204	12205	12207	12208	12210	12213	12215	12217
12250	12254	12258	12261	12265	12268	12272	12306	12312	12315	12320	12321	12322
12325	12326	12500	12524	12527	12533							

Indexation

From 1 July 2023, annual fee indexation will be applied to:

- most of the general medical services items;
- most diagnostic imaging services (but excluding nuclear imaging services); and
- pathology items in Group P12 (74990, 74991, 75861, 75862, 75863 and 75864).

The MBS indexation factor for 1 July 2023 is 3.6 per cent.

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS NOTES

DN.1.1 Electroencephalography (EEG), Prolonged Recording - (item 11003)

Item 11003 covers an extended EEG recording of at least 3 hours duration, other than ambulatory or video recording.

DN.1.2 Electroencephalography (EEG), Ambulatory or Video - (Items 11004 and 11005)

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

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

DN.1.3 Neuromuscular Diagnosis - (Item 11012)

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

DN.1.4 Investigation of Central Nervous System Evoked Responses - (Items 11024 and 11027)

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

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

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

DN.1.5 Electroretinography - (Items 11204, 11205, 11210 and 11211)

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

DN.1.6 Computerised Perimetry Printed Results - (Items 11221 and 11224)

Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 and 11224 should not be used to repeat perimetry unless clinically necessary - such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist.

DN.1.7 Computerised Perimetry - (Items 11221 and 11224)

Item 11221 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11224 for unilateral procedures should be claimed, where appropriate.

DN.1.8 Orbital Contents - (Items 11240, 11241, 11242 and 11243)

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

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

DN.1.10 Electrocochleography - (Item 11304)

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

DN.1.11 Non-determinate Audiometry - (Item 11306)

This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11318 when not performed under the conditions set out in paragraph D1.12.

DN.1.12 Audiology Services - (Items 11309 to 11318)

A medical service specified in Items 11309 to 11318 should be rendered:

(a) in conditions that allow the establishment of determinate thresholds, including better ear threshold in free field testing;

(b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS/NZS 1269.3-2005; and

(c) using calibrated equipment that complies with Australian Standard AS IEC 60645.1-22002, AS IEC 60645.2-2002 and AS IEC 60645.3-2002.

DN.1.13 Oto-Acoustic Emission Audiometry - (Item 11332)

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

DN.1.14 Respiratory Function Tests - (Item 11503)

Specialists and consultant physicians providing services under item 11503 should successfully complete a substantial course of study and training in the relevant test, which has been endorsed by a professional medical organisation. Specialists and consultant physicians should keep appropriate records of this training. Tests should be performed in a respiratory laboratory capable of performing all of, or the majority of the tests listed.

Fractional exhaled nitric oxide (FeNO) testing cannot be claimed under item 11503.

When laboratory based spirometry (item 11512) is performed on the same day as a test approved under item 11503, then only 11503 must be claimed. When spirometry is the only laboratory test performed then 11512 must be claimed.

Maximum inspiratory and expiratory flow-volume loop testing for the purpose of diagnosing central airways obstruction is to be performed under item 11512 not 11503. Item 11503 is not for the purpose of investigation of sleep disorders. Polygraphic data obtained as part of a sleep study item in the range 12203 to 12250 cannot be used for the purpose of claiming item 11503.

For the purposes of item 11503, (c) (iii) measurement of airway or pulmonary resistance by any method includes measurement of nasal resistance by rhinomanometry when performed in a respiratory laboratory.

DN.1.15 Capsule Endoscopy - (Item 11820 and 11823)

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

Capsule endoscopy imaging must be kept in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records must be retained for a period of 2 years commencing on the day on which the service was rendered.

Conjoint committee

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

DN.1.16 Administration of Thyrotropin Alfa-rch for the Detection of Recurrent Well-differentiated Thyroid Cancer - (Item 12201)

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

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

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

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

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

DN.1.17 Investigations for sleep disorders (Items 12203 to 12250)

Items 12203 and 12250 are applicable for patients who require a diagnostic sleep study. They enable direct GP referral to testing without personal assessment by a sleep or respiratory physician, when validated screening questionnaires suggest a high pre-test probability for diagnosis of symptomatic, moderate to severe obstructive sleep apnoea (OSA). The screening questionnaires should be administered by the referring practitioner. Alternatively, the need for testing can be determined by a sleep or respiratory physician following direct clinical assessment (either face-to-face or by video conference).

Screening Questionnaires

For the purpose of items 12203 or 12250, a high probability for symptomatic, moderate to severe OSA would be indicated by one of the following clinical screening tool outcomes:

- STOP-Bang score of 3 or more AND an Epworth Sleepiness Scale score of 8 or more;

OR

- OSA50 score of 5 or more AND an Epworth Sleepiness Scale score of 8 or more;

OR

- high risk score on the Berlin Questionnaire AND an Epworth Sleepiness Scale score of 8 or more.

The STOP-Bang, OSA50, Berlin questionnaires and Epworth Sleepiness Scale can be accessed at Douglas et al, Guidelines for sleep studies in adults - a position statement of the Australasian Sleep Association. Sleep Med. 2017 Aug; 36 Suppl 1:S2-S22 (www.sleep.org.au/documents/item/2980) or on the American Thoracic Society website (www.thoracic.org/members/assemblies/assemblies/srn/questionnaires/).

Evidence of the screening tests being administered to the patient in full, including screening test scores must be recorded in the patient's clinical record as this may be subject to audit.

Out-dated or incomplete referrals (Items 12203 and 12250)

Referrals made prior to 1 November 2018 (or after 1 November 2018 but without the screening questionnaires) remain valid for the purposes of a service performed under items 12203 and 12250 from 1 November 2018 – providing:

- The patient is assessed by a qualified sleep medicine practitioner or consultant respiratory physician to determine the necessity for the sleep study; or
- The validated screening questionnaires are administered to the patient by the sleep medicine practitioner, sleep technician or other practice staff. If the screening questionnaires indicate a high pre-test probability for the diagnosis of symptomatic, moderate to severe OSA, the patient can proceed to testing. If there remains any uncertainty about the necessity for the study, a qualified sleep medicine practitioner or consultant respiratory physician should assess the patient.

Referrals for attended (Level 1) diagnostic studies

Where a patient with suspected OSA has been directly referred for a Level 1 sleep study under item 12203, but there is insufficient information to indicate if there are any contraindications for a Level 2 study, the following options are available:

- The patient can be assessed by a qualified sleep medicine practitioner or consultant respiratory physician to determine the most suitable study (i.e. Level 1 or Level 2); or
- The validated screening questionnaires can be administered to the patient by the sleep medicine practitioner, sleep technician or practice staff. If the screening questionnaires indicate a high pre-test probability for the diagnosis of symptomatic, moderate to severe OSA, the sleep provider can either – arrange for the patient to have a Level 2 study (notifying the referring practitioner of this decision); or seek additional information from the referring practitioner on why a Level 1 study is required (e.g. whether the patient has any contraindications for a Level 2 study). If there remains any uncertainty about the type of study which the patient should receive, a qualified sleep medicine practitioner or consultant respiratory physician should assess the patient.

Referrals made without (or incomplete) screening questionnaires (Items 12203 and 12250)

If a patient has been directly referred for testing without the use of the screening questionnaires, they can be administered to the patient by the sleep provider (e.g. by a sleep technician or other practice staff). Where the screening questionnaires have been provided with the referral but they are incomplete, the sleep provider may wish to contact the patient to determine what their responses were to the relevant questions.

Attended versus unattended sleep studies

Determination of the need for testing should conform with Australasian Sleep Association guidelines.

Unattended sleep studies are suitable for many patients with suspected OSA but patients with other sleep disorders should undergo an attended study. Assessment for potential contraindications to an unattended sleep study can be undertaken by either the referring practitioner, qualified adult sleep medicine practitioner or consultant respiratory physician. Standardised referrals should request sufficient information to enable such assessment.

In accordance with the Australasian Sleep Association's Guidelines for Sleep Studies in Adults, relative contraindications for an unattended sleep study to investigate suspected OSA include but are not limited to:

- (a) intellectual disability or cognitive impairment;
- (b) physical disability with inadequate carer attendance;
- (c) significant co-morbid conditions including neuromuscular disease, heart failure or advanced respiratory disease where more complex disorders are likely;
- (d) suspected respiratory failure where attended measurements are required, including measurement of carbon dioxide partial pressures;
- (e) suspected parasomnia or seizure disorder;
- (f) suspected condition where recording of body position is considered to be essential and would not be recorded as part of an unattended sleep study;
- (g) previously failed or inconclusive unattended sleep study;
- (h) unsuitable home environment including unsafe environments or where patients are homeless; and
- (i) consumer preference based on a high level of anxiety about location of study or where there is unreasonable cost or disruption based on distance to be travelled, or home circumstances.

Patients who have these features may be suitable for either attended (Level 1) or unattended (Level 2) studies.

Treatment options following testing

The results and treatment options following any diagnostic sleep study should be discussed during a professional attendance with a medical practitioner before the initiation of any therapy. If there is uncertainty about the significance of test results or the appropriate management for that individual then referral to a sleep or respiratory medicine specialist is recommended.

Any professional attendance by a qualified sleep medicine practitioner or consultant respiratory physician associated with this service may be undertaken face-to-face or by video conference.

Meaning of 'at least 8 hours'

The requirement 'for at least 8 hours' means the overnight investigation (including patient set-up time and actual period of recording) must be of at least 8 hours duration. Providers must keep evidence of the duration of the overnight investigation (including set-up time and period of recording) as part of their administrative records for MBS sleep studies.

Polygraphic data

Item 11503 is not for the purpose of investigation of sleep disorders. Polygraphic data obtained as part of a sleep study item in the range 12203 to 12250 cannot be used for the purpose of claiming item 11503.

Billing requirements for sleep studies

Items 12203 to 12250 do not support a figurehead billing arrangement. Figurehead or ‘headline’ billing is where one practitioner’s provider number is used to bill patients for the services provided by other practitioners.

While individual components of the sleep study service (e.g. supervision of the investigation and interpretation and preparation of a permanent report) do not need to be performed by the same qualified sleep medicine practitioner, it is an MBS requirement that the qualified sleep medicine practitioner who prepared the report on the results of the investigation bill the relevant item.

Benefits are not payable for items 12203 to 12250 where the interpretation and preparation of a permanent report is provided by a technician or supervised staff rather than by a qualified sleep medicine practitioner.

Where the date of service for a sleep study item is the same as the date of service of any items 11000 to 11005, 11503, 11713 and 12203/12250, for a benefit to be payable, there must be written notification on the account identifying that the service under any of those items was not provided on the same occasion as the sleep study item.

The date of service for the purposes of items 12203 to 12250 is deemed to be the day of the morning the overnight investigation is completed. Billing for the service must only occur once all of the requirements of the item have been fulfilled.

DN.1.18 Bone Densitometry - (Items 12306 to 12322)

Definitions

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

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

Items 12320 and 12322 enable the payment of a Medicare benefit for a bone densitometry service performed on a patient aged 70 years or over. Patients 70 years and over are eligible for an initial screening study.

Patients assessed as having a normal study or mild osteopenia as measured by a t-score down to -1.5 are eligible for one scan every 5 years (item 12320).

Patients with moderate to marked osteopenia as measured by a T-score of -1.5 to -2.5 are eligible for one scan every two years (item 12322).

An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report; all performed by a specialist or consultant physician in the practice of his or her specialty. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. The measurement of bone mineral density at either forearms or both heels or in combination is excluded for the purpose of Medicare benefit, unless necessary for specific clinical indications (see below).

Patients unable to have a lumbar spine or proximal femur measurement taken

The recommended alternative measurement for patients who have been referred for a dual energy x-ray absorptiometry (DEXA) bone densitometry scan who are unable to have a lumbar spine or proximal femur measurement taken is the distal forearm, e.g. patients with spinal fusions or bilateral hip prostheses. Patients unable to have a lumbar spine or proximal femur measurement taken who have been referred for a quantitative computed tomography (QCT) scan are not subject to the two site measurements requirement. For these patients one site for which a QCT measurement can be appropriately referenced is sufficient.

Professional Supervision and Interpretation and Reporting

The interpretation and report for all bone densitometry services must be provided by a specialist or consultant physician.

Items 12306, 12312, 12315, 12321 and Items 12320 and 12322 (when performed using Dual Energy X-ray Absorptiometry) must be performed by a:

- (a) specialist or consultant physician; or
- (b) person who holds a State or Territory radiation license, and who is under the supervision of a specialist or consultant physician.

Items 12320 and 12322 (when performed using Quantitative Computed Tomography) must be performed by a:

- (a) specialist or consultant physician; or
- (b) a radiation licence holder who is registered as a medical radiation practitioner under a law of a State or Territory; and the specialist or consultant physician is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to attend on the patient personally.

Referrals

Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12312, 12315, 12320, 12321 and 12322.

For Item 12306 the referral should specify the indication for the test, namely:

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

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

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

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

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

For Item 12312

- (a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or

(b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day;

for a period anticipated to last for at least 4 months.

Glucocorticoid therapy must be contemporaneous with the current scan. Patients no longer on steroids would not qualify for benefits.

For Item 12312

(a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.

(b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

For Item 12315

A malabsorptive disorder is defined as one or more of the following:

(a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or

(b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or

(c) histologically proven Coeliac disease.

DN.1.19 Retinal Photography with a Non-Mydriatic Retinal Camera

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

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

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

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

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

Any element(s) of the service may be performed by appropriately trained or qualified personnel under the direction of the medical practitioner co-ordinating the patient's care, who retains overall responsibility for claiming of the service.

DN.1.20 Spirometry (Items 11505, 11506 and 11512)

Specialists and consultant physicians providing services under item 11512 should successfully complete a substantial course of study and training in respiratory medicine, which has been endorsed by a professional medical organisation. Specialists and consultant physicians should keep appropriate records of this training.

Spirometry services billed to the MBS should meet international quality standards (Eur Respir J 2005; 26: 319–338).

The National Asthma Council's Australian Asthma Handbook (2016) and Lung Foundation Australia's and Thoracic Society of Australia and New Zealand's COPD-X Plan (2016) advise that properly performed spirometry is required to confirm airflow limitation and the diagnosis of asthma and/or COPD. Reversibility testing is the

standard required for asthma diagnosis. The diagnosis of COPD is confirmed with post bronchodilator spirometry. Item 11505 should not be repeated when diagnosis has been previously confirmed by properly performed spirometry. To meet quality requirements patients must have three acceptable tests for each testing period (pre/post bronchodilator), and meet repeatability criteria with the best effort recorded. Spirometry should be performed by a person who has undergone training and is qualified to perform it to recommended standards (see Spirometry Handbook, National Asthma Council of Australia (<https://www.nationalasthma.org.au/living-with-asthma/resources/health-professionals/information-paper/spirometry-handbook>) and ATS/ERS Standardisation of spirometry paper (<http://erj.ersjournals.com/content/erj/26/2/319.full.pdf>).

DN.1.21 Fraction of Exhaled Nitric Oxide (Item 11507) and Cardiopulmonary Exercise Testing (Item 11508)

Services billed to item 11507 should meet the following quality standards:

- An Official ATS Clinical Practice Guideline: Interpretation of Exhaled Nitric Oxide Levels (FENO) for Clinical Applications: Am J Respir Crit Care Med Vol 184. pp 602–615, 2011 DOI: 10.1164/rccm.912011ST.
- ATS/ERS Recommendations for Standardized Procedures for the Online and Offline Measurement of Exhaled Lower Respiratory Nitric Oxide and Nasal Nitric Oxide, 2005: Am J Respir Crit Care Med Vol 171. pp 912–930, 2005 DOI: 10.1164/rccm.200406-710ST

Fewer than three traces will be accepted as billable under item 11507 if three reproducible loops are difficult to achieve for clinical reasons. The clinical reason(s) for not achieving three reproducible loops must be documented.

Services billed to item 11508 should meet the following quality standards:

- Radtke T, Crook S, Kaltsakas G, et al. ERS statement on standardisation of cardiopulmonary exercise testing in chronic lung diseases. Eur Respir Rev 2019; 28: 180101 [<https://doi.org/10.1183/16000617.0101-2018>]
- Hallstrand TS, Leuppi JD, Joos G, et al. ERS technical standard on bronchial challenge testing: pathophysiology and methodology of indirect airway challenge testing. Eur Respir J 2018; 52: 1801033 [<https://doi.org/10.1183/13993003.01033-2018>]

For perioperative indications, the test should be conducted according to international guidelines: Perioperative cardiopulmonary exercise testing (CPET): consensus clinical guidelines on indications, organization, conduct, and physiological interpretation for the purpose of preoperative assessment and optimisation for major surgery (published by the Perioperative Exercise and Training Society [POETTS]; British Journal of Anaesthesia, 2018).

Specialists and consultant physicians providing services under item 11508 should successfully complete a substantial course of study and training in cardiopulmonary exercise testing, which has been endorsed by a professional medical organisation. Specialists and consultant physicians should keep appropriate records of this training.

DN.1.22 Skin Prick Testing (items 12000-12005)

Skin prick testing and Intradermal testing should always be performed in a medical setting with the ready availability of medical practitioners competent to treat systemic allergic reactions, and appropriate resuscitation equipment. Because intradermal testing carries a higher risk of anaphylaxis it should only be performed in a hospital setting (or equivalent) by either a specialist or consultant physician with proficiency and experience in all aspects of skin testing for allergy.

Item 12003 should only be used by appropriately trained doctors such as allergist immunologists or equivalently trained medical practitioners. An alternative to Skin Prick Testing (SPT) is serum specific IgE food allergen testing. Serum specific IgE (ssIgE) allergy blood testing to food panels is not recommended.

Item 12004 should only be used by appropriately trained doctors such as allergist immunologists or equivalently trained medical practitioners.

Item 12005 should only be used by appropriately trained doctors such as allergist immunologists, anaesthetists or equivalently trained medical practitioners.

DN.1.23 Multiple sleep latency testing and Maintenance of wakefulness testing

Determination of the need for testing and testing procedures should be performed in accordance with current Australasian Sleep Association guidelines. Not to be used as part of an occupational health service or pre-employment assessment.

The date of service for the purposes of items 12254 to 12272 is deemed to be the day on which the daytime investigation component of the test is completed. Billing for the service must only occur once all of the requirements of the item have been fulfilled.

DN.1.24 Electroencephalography (item 11000)

Routine electroencephalography should not be performed for the following indications/presentations, except after discussion with a Neurologist. In some of these situations a routine EEG is of relatively low diagnostic value, while in others it would be more appropriate to refer the patient directly for a prolonged EEG, or to a Neurologist for consultation and possible further investigation:

- Suspected Psychogenic Non-Epileptic Seizures (PNES)
- Syncope
- Exclusion of a mass lesion
- Headache & migraine
- Behavioural disturbance/aggression
- Tics
- Postural dizziness
- Non-specific fatigue
- Intellectual impairment
- Paediatric simple febrile seizures
- Breath-holding spells
- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

DN.1.26 Discussion of results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.27 Implanted ECG Loop Recording (Item 11731)

- i. Also permissible for babies, young children and other patients, due to the patient's age, cognitive capacity or expressive language impairment, where symptoms have not been satisfactorily investigated by other methods.
- ii. Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.28 Indications considered appropriate & Discussion of Results (Item 11716)

Indications interpretation

The following indications would be considered appropriate even in patients who may not experience symptoms more often than once a week.

- a. For the detection of asymptomatic atrial fibrillation (AF) following a transient ischaemic attack (TIA) or cryptogenic stroke.
- b. For the surveillance of paediatric patients following cardiac surgeries that have an established risk of causing dysrhythmia.
- c. For babies, young children and other patients where there is a demonstrable benefit for the documentation of heart rate or if a cardiac dysrhythmia is suspected, but due to the patient's age, cognitive capacity or expressive language impairment, it is not possible to accurately assess symptom frequency based on medical history.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.29 Multi- channel ECG monitoring & recording 17 years & over (Item 11729)

Indication interpretation

Heritable arrhythmias include those defined in the [CSANZ guidelines](#) for the diagnosis and management of catecholaminergic polymorphic ventricular tachycardia, familial long QT syndrome and genetic investigation of young sudden unexplained death and resuscitated out of hospital cardiac arrest.

A calcium score of zero is normal and clinician judgement should be applied for scores of 0–10.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.30 Multi-channel ECG monitoring & recording Under 17 years (Item 11730)

Indications interpretation

Heritable arrhythmias include those defined in the [CSANZ guidelines](#) for the diagnosis and management of catecholaminergic polymorphic ventricular tachycardia, familial long QT syndrome and genetic investigation of young sudden unexplained death and resuscitated out of hospital cardiac arrest.

Results

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

Paediatric Investigation and Consultation

For investigations performed by a specialist paediatric cardiologist, co-claiming of a consultation with the investigation is permitted even when a consultation was not specifically requested when:

- the paediatric patient was referred for an investigation; and
- the paediatric patient was not known to the provider; and
- the paediatric patient was not under the care of another paediatric cardiologist; and
- the findings on the investigation appropriately warranted a consultation.

DN.1.31 ECG Report (Items 11704 and 11705)

The formal report is separate to any letter and entails interpretation of the trace commenting on the significance of the trace findings and their relationship to clinical decision making for the patient in their clinical context, in addition to any measurements taken or automatically generated.

DN.1.32 Neuromuscular electrodiagnosis (items 11012, 11015 and 11018)

Nerve conduction studies and/or EMG should not be used in the following indications/situations. In some of these situations these tests would be of relatively low diagnostic value, while in others it would be more appropriate to refer the patient for alternative investigations first (e.g. magnetic resonance imaging [MRI] in mild radiculopathy)

- Muscle pain in the absence of other abnormalities on examination or laboratory testing
- A four limb needle EMG/nerve conduction study for neck and back pain after trauma
- EMG for low back pain without leg pain or sciatica.

DN.1.33 Requirement of Medical Practitioner

Performed where a medical practitioner is immediately available to attend the patient for the purposes of review and can have an impact of patient outcomes, where such testing is clinically indicated.

DN.1.34 Formal Report

Discussions of the results, findings or interpretation of a study are reasonably expected to be part of a formal report. Discussion of these findings with a patient does not constitute a consult. Similarly, discussion(s) during the course of a study or to determine the safety or appropriateness of the study is part of the service and should not be claimed as a consult.

DN.1.35 Treatment plan guidelines and additional claiming guidelines for ambulatory blood pressure monitoring

Treatment plan guidelines for ambulatory blood pressure monitoring

To fulfil the treatment plan of item 11607, a comprehensive written plan must be prepared describing:

- a. the patient's diagnosis;
- b. management goals with which the patient agrees;
- c. appropriate interventions including lifestyle modification;

- d. treatment the patient may need; 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.

Additional Claiming Guidelines for ambulatory blood pressure monitoring:

Blood pressure monitoring equipment:

Both the in-clinic blood pressure monitor and the ambulatory blood monitoring equipment (cuff and monitor) used for services under item 11607 must be listed on the Australian Register of Therapeutic Goods, with monitoring devices recalibrated at time intervals as per the manufacturer's recommendations.

Claiming separate consultations:

If a consultation is for the purpose of an Ambulatory blood pressure monitoring treatment plan, a separate and additional consultation should not be undertaken in conjunction with the Ambulatory blood pressure monitoring consultation, unless it is clinically indicated that a separate problem must be treated immediately.

Where a separate consultation is undertaken in conjunction with an Ambulatory blood pressure monitoring consultation, 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).

DN.1.36 Audiology Services - (Items 11340, 11341 and 11343)

All vestibular assessment tests to be performed as indicated by standard clinical practice and must provide a quantifiable measure.

A single test is defined as one of the following:

- Video Head Impulse Test (vHIT) (up to all planes tested and +/- Suppression HIT);
- Ocular Vestibular Evoked Myogenic Potential (O VEMP) +/- threshold testing (air and/or bone conduction and/or skull-tap);
- Cervical Vestibular Evoked Myogenic Potential (C VEMP) +/- threshold testing (air and/or bone conduction and/or skull-tap);
- Videonystagmography (VNG) or Electronystagmography (ENG) to measure ocular-motor responses including spontaneous/gaze evoked nystagmus, optokinetic, saccade or smooth pursuit function;

- Videonystagmography (VNG) or Electronystagmography(ENG) to measure eye movement in response to positional testing +/- Dix-Hallpike +/- mechanical positioning;
- Videonystagmography (VNG) or Electronystagmography (ENG) to measure eye movement responses to stimuli such as pressure and sound (Tullio and/or Fistula testing), and/or hyperventilation and/or head shaking;
- Calorics, and/or Caloric Test of Labyrinth;
- Rotational testing including rotational chair;
- Subjective visual vertical/horizontal;
- Static posturography or Computerised Dynamic Posturography (CDP).

DR.1.1 AECG requirements for claiming

Items 11716, 11717, 11723 or 11735 do not apply to a service unless:

- (i) the patient is referred to a specialist or consultant physician by a referring practitioner; or
- (ii) the service is requested by a requesting practitioner.

Admitted patient

Item 11716, 11717, 11723 or 11735 do not apply to a service if the patient is an admitted patient.

An “admitted patient” includes an episode of hospital treatment and an episode of hospital-substitute treatment where a benefit is paid from a private health insurer.

Referred services

For referred services to which items 11716, 11717, 11723 or 11735 apply, the specialist or consultant physician who renders the service must:

- (i) manage the ongoing care of the patient; or
- (ii) perform an attendance to determine that testing is necessary, where the need for the test has not otherwise been scheduled; or
- (iii) perform an attendance immediately after the test has been performed, at which clinical management decisions are discussed with the patient.

A service is taken to be referred if the specialist or consultant physician who renders the service to which items 11716, 11717, 11723 or 11735 applies is the patient’s treating practitioner, determines the need for a cardiac investigation that has not otherwise been scheduled, or performs a scheduled test but also provides an attendance where clinical management decisions are discussed with the patient. Services in all other circumstances are considered to be requested.

Requested services

- (i) for requested services, items 11716, 11717, 11723 or 11735 do not apply to a service if the rendering specialist or consultant physician has performed a service to which an attendance applies for the same patient on the same day.
- (ii) definition of 'requesting practitioner' when applied to items 11716, 11717, 11723 or 11735 is as follows:
 - a. a medical practitioner (other than a specialist or consultant physician) requests that a specialist or consultant physician provide the service.
 - b. a specialist or consultant physician requests that a separate specialist or consultant physician provide the service.

DR.1.2 Exercise ECG stress testing requirements for claiming - Item 11729

This service can be performed as an out-of-hospital service or for admitted hospital patients.

Item 11729 does not apply to a service unless:

- i. the patient is referred to a specialist or consultant physician by a referring practitioner; or
- ii. the service is requested by a requesting practitioner.

Referred services

For referred services to which item 11729 applies, the specialist or consultant physician who renders the service must:

- i. manage the ongoing care of the patient; or
- ii. perform an attendance to determine that testing is necessary, where the need for the test has not otherwise been scheduled; or
- iii. perform an attendance immediately after the test has been performed, at which clinical management decisions are discussed with the patient.

A service is taken to be referred if the specialist or consultant physician who renders the service to which item 11729 applies is the patient's treating practitioner, determines the need for a cardiac investigation that has not otherwise been scheduled, or performs a scheduled test but also provides an attendance where clinical management decisions are discussed with the patient. Services in all other circumstances are considered to be requested.

Requested services

For requested services, item 11729 does not apply to a service if the rendering medical practitioner has performed a service to which an attendance applies for the same patient on the same day unless **both** of the following apply:

- i. another medical practitioner has requested the electrocardiogram service; and
- ii. the attendance service is provided at the same time as, or after, the electrocardiogram service and is required because there is an urgent clinical need to make decisions about the patient's care as a result of the electrocardiogram service.

Definition of 'requesting practitioner' when applied to item 11729 is as follows:

- i. a medical practitioner (other than a specialist or consultant physician) requests that a specialist or consultant physician provide the diagnostic service; or
- ii. a specialist or consultant physician requests that a separate specialist or consultant physician provide the diagnostic service; or
- iii. a medical practitioner (other than a specialist or consultant physician) requests that a medical practitioner (other than a specialist or consultant physician) provide the diagnostic service; or
- iv. a specialist or consultant physician requests that a medical practitioner (other than a specialist or consultant physician) provide the diagnostic service.

Patient requirements

- i. Item 11729 does not apply to a service unless:
the patient's body habitus, or other physical condition, is suitable for exercise stress testing or pharmacological induced stress testing; and
- ii. the patient can complete the exercise sufficiently or respond adequately to pharmacological induced stress, to take the required measurements.

Item 11729 does not apply to a service performed on a patient who:

- (i) is asymptomatic and has a normal cardiac examination; or
- (ii) has a known cardiac disease but the absence of symptom evolution suggests the disease has not progressed and the service is used for monitoring; or
- (iii) has an abnormal resting electrocardiography result which would prevent the interpretation of results.

Exercise testing and cardiopulmonary resuscitation

The Taskforce recommended changes to the performance of exercise or pharmacological electrocardiogram stress testing for optimal patient safety. For a service to be performed, the person performing the monitoring and recording must be:

- a. in continuous attendance; and
- b. trained in “exercise testing” and cardiopulmonary resuscitation; and
- c. a second person trained in cardiopulmonary resuscitation must be located at the premise and available to attend the electrocardiogram stress testing in an emergency.

Please refer to the Cardiac Society of Australia and New Zealand position statement on clinical exercise stress testing: https://www.csanz.edu.au/wp-content/uploads/2014/12/Clinical_Exercise_Stress_Testing_2014-December.pdf

DR.1.3 Paediatric Exercise ECG stress testing claiming requirements

This service can be performed as an out-of-hospital service or for admitted hospital patients.

Item 11730 does not apply to a service unless:

- (i) the patient’s body habitus, or other physical condition, is suitable for exercise stress testing or pharmacological induced stress testing; and
- (ii) the patient can complete the exercise sufficiently or respond adequately to pharmacological induced stress, to take the required measurements; and
- (iii) one of the persons mentioned in subparagraphs b(iv) and (v) of the item descriptor must be a medical practitioner.

Item 11730 does not apply to a service performed on a patient who is asymptomatic and has a normal cardiac examination.

Exercise testing and cardiopulmonary resuscitation

The Taskforce recommended changes to the performance of exercise or pharmacological electrocardiogram stress testing for optimal patient safety. For a service to be performed, the person performing the monitoring and recording must be:

- i. in continuous attendance; and
- ii. trained in “exercise testing” and cardiopulmonary resuscitation; and
- iii. A second person trained in cardiopulmonary resuscitation must be located at the premise and available to attend the electrocardiogram stress testing in an emergency.

Please refer to the Cardiac Society of Australia and New Zealand position statement on clinical exercise stress testing:

https://www.csanz.edu.au/wp-content/uploads/2014/12/Clinical_Exercise_Stress_Testing_2014-December.pdf

DR.1.4 12-lead electrocardiography requirements for claiming

There are four 12-lead electrocardiography items:

- Item 11704 for a trace and formal report service performed by a specialist or consultant physician.
- Item 11705 for a formal report service performed by a specialist or consultant physician, where the specialist reports on a trace.

- Item 11707 for a trace service performed by a medical practitioner.
- Item 11714 for trace and clinical note service performed by a specialist or consultant physician.

Admitted patient

Items 11704, 11707 and 11714 do not apply where the patient is an “admitted patient” of a hospital. An “admitted patient” includes an episode of hospital treatment and an episode of hospital-substitute treatment where a benefit is paid from a private health insurer. Item 11705 can be performed out-of-hospital or for admitted hospital patients.

Requested service

- a) Items 11704 and 11705 are requested services which require the rendering specialist or consultant physician to produce a written formal report which must be provided to the requesting practitioner. The rendering specialist or consultant physician cannot perform the service unless it has been requested by another medical practitioner.
- b) As a requested service, it is generally not expected that items 11704 or 11705 would involve any clinical work beyond performing the formal report (and the trace for item 11704). The MBS Review Taskforce recommended that an attendance should not be co-claimed with a diagnostic cardiac investigation in these circumstances. Item 11704 cannot be claimed if the rendering specialist or consultant physician has performed an attendance on the same patient on the same day.

Generally, it is expected that item 11705 should not be co-claimed with an attendance, but in exceptional clinical circumstances an attendance can be performed i.e. an admitted patient requires a formal report (on a trace) to be provided by a cardiologist and the result of this reporting determines that an urgent attendance (life threatening) is required by the cardiologist to guide immediate treatment (particularly when there is only one cardiologist rostered on the shift).

Financial relationship

The rendering specialist or consultant physician and the requesting practitioner cannot have a financial relationship. Definition of ‘financial relationship’: is where the requesting practitioner is a member of a group of practitioners of which the providing practitioners is a member (both the requestor and provider potentially financially benefit from the MBS service provided). The need for a request should be informed by a clinical decision only.

Item 11707

Item 11707 is a trace only service and can be performed by any medical practitioner.

Item 11714

Item 11714 allows specialist and consultant physicians to perform an electrocardiography trace and interpret the results (in the form of producing a written clinical note) where they consider it necessary for the management or treatment of the patient. No request is required for this service. There is no limitation on the claiming of an attendance with item 11714, as the Taskforce agreed that performance of an electrocardiography was part of routine assessment for patients presenting to specialist and consultant physicians for management of their cardiac condition.

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS ITEMS

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		1. NEUROLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 1. Neurology	
	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.)	
Fee 11000	(See para DN.1.24 of explanatory notes to this Category) Fee: \$134.85 Benefit: 75% = \$101.15 85% = \$114.65	
	Electroencephalography, prolonged recording lasting at least 3 hours, that requires multi-channel recording using: (a) for a service not associated with a service to which an item in Group T8 applies—standard 10-20 electrode placement; or (b) for a service associated with a service to which an item in Group T8 applies—either standard 10-20 electrode placement or a different electrode placement and number of recorded channels; other than a service: (c) associated with a service to which item 11000, 11004 or 11005 applies; or (d) involving quantitative topographic mapping using neurometrics or similar devices.	
Fee 11003	(See para DN.1.1 of explanatory notes to this Category) Fee: \$356.65 Benefit: 75% = \$267.50 85% = \$303.20	
	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, first day, other than a service: (a) associated with a service to which item 11000, 11003 or 11005 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices.	
Fee 11004	(See para DN.1.2 of explanatory notes to this Category) Fee: \$356.65 Benefit: 75% = \$267.50 85% = \$303.20	
	Electroencephalography, ambulatory or video, prolonged recording lasting at least 3 hours and up to 24 hours, that requires multi channel recording using standard 10-20 electrode placement, each day after the first day, other than a service: (a) associated with a service to which item 11000, 11003 or 11004 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices.	
Fee 11005	(See para DN.1.2 of explanatory notes to this Category) Fee: \$356.65 Benefit: 75% = \$267.50 85% = \$303.20	
Fee 11009	ELECTROCORTICOGRAPHY Fee: \$356.65 Benefit: 75% = \$267.50 85% = \$303.20	
	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies)	
Fee 11012	(See para DN.1.3, DN.1.32 of explanatory notes to this Category) Fee: \$122.65 Benefit: 75% = \$92.00 85% = \$104.30	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		1. NEUROLOGY
Fee 11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) (See para DN.1.32 of explanatory notes to this Category) Fee: \$164.20 Benefit: 75% = \$123.15 85% = \$139.60	
Fee 11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) (See para DN.1.32 of explanatory notes to this Category) Fee: \$245.30 Benefit: 75% = \$184.00 85% = \$208.55	
Fee 11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations Fee: \$164.20 Benefit: 75% = \$123.15 85% = \$139.60	
Fee 11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 1 or 2 studies (See para DN.1.4 of explanatory notes to this Category) Fee: \$124.70 Benefit: 75% = \$93.55 85% = \$106.00	
Fee 11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials or multifocal multichannel objective perimetry - 3 or more studies (See para DN.1.4 of explanatory notes to this Category) Fee: \$184.95 Benefit: 75% = \$138.75 85% = \$157.25	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		2. OPHTHALMOLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 2. Ophthalmology	
Fee 11200	PROVOCATIVE TEST OR TESTS FOR OPEN ANGLE GLAUCOMA, including water drinking Fee: \$44.70 Benefit: 75% = \$33.55 85% = \$38.00	
Fee 11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality. (See para DN.1.5 of explanatory notes to this Category) Fee: \$118.55 Benefit: 75% = \$88.95 85% = \$100.80	
Fee 11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards, performed by or on behalf of a specialist or consultant physician in the practice of his or her speciality. (See para DN.1.5 of explanatory notes to this Category) Fee: \$118.55 Benefit: 75% = \$88.95 85% = \$100.80	
Fee 11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards (See para DN.1.5 of explanatory notes to this Category) Fee: \$118.55 Benefit: 75% = \$88.95 85% = \$100.80	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		2. OPHTHALMOLOGY
Fee 11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m ²) estimation of threshold in log lumens at 45 minutes of dark adaptations (See para DN.1.5 of explanatory notes to this Category) Fee: \$118.55 Benefit: 75% = \$88.95 85% = \$100.80	
Fee 11215	RETINAL ANGIOGRAPHY, multiple exposures of 1 eye with intravenous dye injection Fee: \$134.70 Benefit: 75% = \$101.05 85% = \$114.50	
Fee 11218	RETINAL ANGIOGRAPHY, multiple exposures of both eyes with intravenous dye injection Fee: \$166.45 Benefit: 75% = \$124.85 85% = \$141.50	
Fee 11219	Optical coherence tomography for diagnosis of an ocular condition for the treatment of which there is a medication that is: (a) listed on the pharmaceutical benefits scheme; and (b) indicated for intraocular administration Applicable only once in any 12 month period Fee: \$43.75 Benefit: 75% = \$32.85 85% = \$37.20	
Fee 11220	OPTICAL COHERENCE TOMOGRAPHY for the assessment of the need for treatment following provision of pharmaceutical benefits scheme-subsidised ocriplasmin. Maximum of one service per eye per lifetime. Fee: \$43.75 Benefit: 75% = \$32.85 85% = \$37.20	
Fee 11221	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if 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 3 examinations (including examinations to which item 11224 applies) in any 12 month period (See para DN.1.6, DN.1.7 of explanatory notes to this Category) Fee: \$74.30 Benefit: 75% = \$55.75 85% = \$63.20	
Fee 11224	Full quantitative computerised perimetry (automated absolute static threshold), other than a service involving multifocal multichannel objective perimetry, performed by or on behalf of a specialist in the practice of his or her specialty, if 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 3 examinations (including examinations to which item 11221 applies) in any 12 month period (See para DN.1.6, DN.1.7 of explanatory notes to this Category) Fee: \$44.75 Benefit: 75% = \$33.60 85% = \$38.05	
Fee 11235	EXAMINATION OF THE EYE BY IMPRESSION CYTOLOGY OF CORNEA for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report Fee: \$134.40 Benefit: 75% = \$100.80 85% = \$114.25	
Fee 11237	OCULAR CONTENTS, simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, not being a service associated with a service to which items in Group I1 of Category 5 apply	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		2. OPHTHALMOLOGY
	Fee: \$89.20 Benefit: 75% = \$66.90 85% = \$75.85	
Fee 11240	<p>ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 of Category 5 apply.</p> <p>(See para DN.1.8 of explanatory notes to this Category)</p> <p>Fee: \$89.20 Benefit: 75% = \$66.90 85% = \$75.85</p>	
Fee 11241	<p>ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply</p> <p>(See para DN.1.8 of explanatory notes to this Category)</p> <p>Fee: \$113.55 Benefit: 75% = \$85.20 85% = \$96.55</p>	
Fee 11242	<p>ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply</p> <p>(See para DN.1.8 of explanatory notes to this Category)</p> <p>Fee: \$87.75 Benefit: 75% = \$65.85 85% = \$74.60</p>	
Fee 11243	<p>ORBITAL CONTENTS, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply</p> <p>(See para DN.1.8 of explanatory notes to this Category)</p> <p>Fee: \$87.75 Benefit: 75% = \$65.85 85% = \$74.60</p>	
Fee 11244	<p>Orbital contents, diagnostic B-scan of, by a specialist practising in his or her speciality of ophthalmology, not being a service associated with a service to which an item in Group I1 of the diagnostic imaging services table applies.</p> <p>Fee: \$84.35 Benefit: 75% = \$63.30 85% = \$71.70</p>	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		3. OTOLARYNGOLOGY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 3. Otolaryngology	
Fee 11300	<p>Brain stem evoked response audiometry if:</p> <p>(a) the service is not for the purposes of programming either an auditory implant or the sound processor of an auditory implant; and</p> <p>(b) a service to which item 82300 applies has not been performed on the patient on the same day</p> <p>other than a service associated with a service to which item 11340, 11341 or 11343 applies (Anaes.)</p> <p>Fee: \$210.85 Benefit: 75% = \$158.15 85% = \$179.25</p>	
Fee 11302	<p>Programming an auditory implant or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which item 82301, 82302 or 82304 applies has not been performed on the patient on the same day</p> <p>Applicable up to a total of 4 services to which this item, item 11342 or item 11345 applies on the same day</p>	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		3. OTOLARYNGOLOGY
	Fee: \$210.85 Benefit: 75% = \$158.15 85% = \$179.25	
Fee 11303	ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears Fee: \$210.85 Benefit: 75% = \$158.15 85% = \$179.25	
Fee 11304	ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears (See para DN.1.10 of explanatory notes to this Category) Fee: \$347.15 Benefit: 75% = \$260.40 85% = \$295.10	
Fee 11306	Non determinate audiometry, if a service to which item 82306 applies has not been performed on the patient on the same day. (See para DN.1.11 of explanatory notes to this Category) Fee: \$24.00 Benefit: 75% = \$18.00 85% = \$20.40	
Fee 11309	Audiogram, air conduction, if a service to which item 82309 applies has not been performed on the patient on the same day. (See para DN.1.12, DN.1.11 of explanatory notes to this Category) Fee: \$28.80 Benefit: 75% = \$21.60 85% = \$24.50	
Fee 11312	Audiogram, air and bone conduction or air conduction and speech discrimination, if a service to which item 82312 applies has not been performed on the patient on the same day. (See para DN.1.12, DN.1.11 of explanatory notes to this Category) Fee: \$40.65 Benefit: 75% = \$30.50 85% = \$34.60	
Fee 11315	Audiogram, air and bone conduction and speech, if a service to which item 82315 applies has not been performed on the patient on the same day (See para DN.1.12, DN.1.11 of explanatory notes to this Category) Fee: \$53.85 Benefit: 75% = \$40.40 85% = \$45.80	
Fee 11318	Audiogram, air and bone conduction and speech, with other cochlear tests, if a service to which item 82318 applies has not been performed on the patient on the same day (See para DN.1.12, DN.1.11 of explanatory notes to this Category) Fee: \$66.50 Benefit: 75% = \$49.90 85% = \$56.55	
Fee 11324	Impedance audiogram involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a medical practitioner, if a service to which item 82324 applies has not been performed on the patient on the same day Fee: \$21.75 Benefit: 75% = \$16.35 85% = \$18.50	
Fee 11332	Oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlear, performed by or on behalf of a specialist or consultant physician, when middle ear pathology has been excluded, if: (a) the service is performed: (i) on an infant or child who is at risk of permanent hearing impairment; or (ii) on an individual who is at risk of oto-toxicity due to medications or medical intervention; or (iii) on an individual at risk of noise induced hearing loss; or (iv) to assist in the diagnosis of auditory neuropathy; and (b) a service to which item 82332 applies has not been performed on the patient on the same day (See para DN.1.13 of explanatory notes to this Category) Fee: \$64.20 Benefit: 75% = \$48.15 85% = \$54.60	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

3. OTOLARYNGOLOGY

<p>Fee 11340</p>	<p>Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner:</p> <p>(a) to assess one or more of the following:</p> <p>(i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve);</p> <p>(ii) muscular or eye movement responses elicited by vestibular stimulation;</p> <p>(iii) static signs of vestibular dysfunction;</p> <p>(iv) the central ocular-motor function; and</p> <p>(b) using up to 2 clinically recognised tests;</p> <p>other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies</p> <p>(See para DN.1.36 of explanatory notes to this Category) Fee: \$203.90 Benefit: 75% = \$152.95 85% = \$173.35</p>
<p>Fee 11341</p>	<p>Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner:</p> <p>(a) to assess one or more of the following:</p> <p>(i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve);</p> <p>(ii) muscular or eye movement responses elicited by vestibular stimulation;</p> <p>(iii) static signs of vestibular dysfunction;</p> <p>(iv) the central ocular-motor function; and</p> <p>(b) using 3 or 4 clinically recognised tests;</p> <p>other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies</p> <p>(See para DN.1.36 of explanatory notes to this Category) Fee: \$408.70 Benefit: 75% = \$306.55 85% = \$347.40</p>
<p>Fee 11342</p>	<p>Programming by telehealth of an auditory implant, or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which items 82301, 82302 or 82304 applies has not been performed on the patient on the same day</p> <p>Applicable up to a total of 4 services to which this item, item 11302 or item 11345 applies on the same day</p> <p>Fee: \$168.60 Benefit: 85% = \$143.35</p>
<p>Fee 11343</p>	<p>Investigation of the vestibular function to assist in the diagnosis, treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner:</p> <p>(a) to assess one or more of the following:</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		3. OTOLARYNGOLOGY
	<p>(i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve);</p> <p>(ii) muscular or eye movement responses elicited by vestibular stimulation;</p> <p>(iii) static signs of vestibular dysfunction;</p> <p>(iv) the central ocular-motor function; and</p> <p>(b) using 5 or more clinically recognised tests;</p> <p>other than a service associated with a service to which item 11015, 11021, 11024, 11027, 11205 or 11300 applies</p> <p>(See para DN.1.36 of explanatory notes to this Category)</p> <p>Fee: \$611.50 Benefit: 75% = \$458.65 85% = \$519.80</p>	
Fee 11345	<p>Programming by phone of an auditory implant, or the sound processor of an auditory implant, unilateral, performed by or on behalf of a medical practitioner, if a service to which items 82301, 82302 or 82304 applies has not been performed on the patient on the same day</p> <p>Applicable up to a total of 4 services to which this item, item 11302 or item 11342 applies on the same day</p> <p>Fee: \$168.60 Benefit: 85% = \$143.35</p>	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		4. RESPIRATORY
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 4. Respiratory	
Fee 11503	<p>Complex measurement of properties of the respiratory system, including the lungs and respiratory muscles, that is performed:</p> <p>(a) in a respiratory laboratory; and</p> <p>(b) under the supervision of a specialist or consultant physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports on tests performed; and</p> <p>(c) using any of the following tests:</p> <p style="padding-left: 40px;">(i) measurement of absolute lung volumes by any method;</p> <p style="padding-left: 40px;">(ii) measurement of carbon monoxide diffusing capacity by any method;</p> <p style="padding-left: 40px;">(iii) measurement of airway or pulmonary resistance by any method;</p> <p style="padding-left: 40px;">(iv) inhalation provocation testing, including pre-provocation spirometry and the construction of a dose response curve, using a recognised direct or indirect bronchoprovocation agent and post-bronchodilator spirometry;</p> <p style="padding-left: 40px;">(v) provocation testing involving sequential measurement of lung function at baseline and after exposure to specific sensitising agents, including drugs, or occupational asthma triggers;</p>	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

4. RESPIRATORY

	<p>(vi) spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises equipped with resuscitation equipment and personnel trained in Advanced Life Support;</p> <p>(vii) measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes;</p> <p>(viii) simulated altitude test involving exposure to hypoxic gas mixtures and oxygen saturation at rest and/or during exercise with or without an observation of the effect of supplemental oxygen;</p> <p>(ix) calculation of pulmonary or cardiac shunt by measurement of arterial oxygen partial pressure and haemoglobin concentration following the breathing of an inspired oxygen concentration of 100% for a duration of 15 minutes or greater;</p> <p>(x) if the measurement is for the purpose of determining eligibility for pulmonary arterial hypertension medications subsidised under the Pharmaceutical Benefits Scheme or eligibility for the provision of portable oxygen—functional exercise test by any method (including 6 minute walk test and shuttle walk test);</p> <p>each occasion at which one or more tests are performed</p> <p>Not applicable to a service performed in association with a spirometry or sleep study service to which item 11505, 11506, 11507, 11508, 11512, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Not applicable to a service to which item 11507 applies</p> <p>(See para DN.1.14 of explanatory notes to this Category) Fee: \$151.85 Benefit: 75% = \$113.90 85% = \$129.10</p>
<p>Fee 11505</p>	<p>Measurement of spirometry, that:</p> <p>(a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and</p> <p>(b) is performed to confirm diagnosis of:</p> <p style="padding-left: 20px;">(i) asthma; or</p> <p style="padding-left: 20px;">(ii) chronic obstructive pulmonary disease (COPD); or</p> <p style="padding-left: 20px;">(iii) another cause of airflow limitation;</p> <p>each occasion at which 3 or more recordings are made</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.20 of explanatory notes to this Category) Fee: \$45.05 Benefit: 75% = \$33.80 85% = \$38.30</p>
<p>Fee 11506</p>	<p>Measurement of spirometry, that:</p> <p>(a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and</p> <p>(b) is performed to:</p> <p style="padding-left: 20px;">(i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	4. RESPIRATORY
	<p>(ii) assess acute exacerbations of asthma; or</p> <p>(iii) monitor asthma and COPD; or</p> <p>(iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease;</p> <p>each occasion at which recordings are made</p> <p>(See para DN.1.20 of explanatory notes to this Category)</p> <p>Fee: \$22.55 Benefit: 75% = \$16.95 85% = \$19.20</p>
<p>Fee 11507</p>	<p>Measurement of spirometry:</p> <p>(a) that includes continuous measurement of the relationship between flow and volume during expiration or during expiration and inspiration, performed before and after inhalation of a bronchodilator; and</p> <p>(b) fractional exhaled nitric oxide (FeNO) concentration in exhaled breath;</p> <p>if:</p> <p>(c) the measurement is performed:</p> <p style="padding-left: 40px;">(i) under the supervision of a specialist or consultant physician; and</p> <p style="padding-left: 40px;">(ii) with continuous attendance by a respiratory scientist; and</p> <p style="padding-left: 40px;">(iii) in a respiratory laboratory equipped to perform complex lung function tests; and</p> <p>(d) a permanently recorded tracing and written report is provided; and</p> <p>(e) 3 or more spirometry recordings are performed unless difficult to achieve for clinical reasons;</p> <p>each occasion at which one or more such tests are performed</p> <p>Not applicable to a service associated with a service to which item 11503 or 11512 applies</p> <p>(See para DN.1.21 of explanatory notes to this Category)</p> <p>Fee: \$109.75 Benefit: 75% = \$82.35 85% = \$93.30</p>
<p>Fee 11508</p>	<p>Maximal symptom-limited incremental exercise test using a calibrated cycle ergometer or treadmill, if:</p> <p>(a) the test is performed for the evaluation of:</p> <p style="padding-left: 40px;">(i) breathlessness of uncertain cause from tests performed at rest; or</p> <p style="padding-left: 40px;">(ii) breathlessness out of proportion with impairment due to known conditions; or</p> <p style="padding-left: 40px;">(iii) functional status and prognosis in a patient with significant cardiac or pulmonary disease for whom complex procedures such as organ transplantation are considered; or</p> <p style="padding-left: 40px;">(iv) anaesthetic and perioperative risks in a patient undergoing major surgery who is assessed as substantially above average risk after standard evaluation; and</p> <p>(b) the test has been requested by a specialist or consultant physician following professional attendance on the patient by the specialist or consultant physician; and</p> <p>(c) a respiratory scientist and a medical practitioner are in constant attendance during the test; and</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

5. VASCULAR

<p>Fee 11602</p>	<p>Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or Valsalva manoeuvres, or both, to detect prograde and retrograde flow, other than a service associated with a service to which item 32500 applies—hard copy trace and written report, the report component of which must be performed by a medical practitioner, maximum of 2 examinations in a 12 month period, not to be used in conjunction with sclerotherapy</p> <p>Fee: \$63.25 Benefit: 75% = \$47.45 85% = \$53.80</p>
<p>Fee 11604</p>	<p>Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography)—examination, hard copy trace and written report, not being a service associated with a service to which item 32500 applies</p> <p>Fee: \$82.90 Benefit: 75% = \$62.20 85% = \$70.50</p>
<p>Fee 11605</p>	<p>Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease—hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 applies</p> <p>Fee: \$82.90 Benefit: 75% = \$62.20 85% = \$70.50</p>
<p>Fee 11607</p>	<p>Continuous ambulatory blood pressure recording for 24 hours or more for a patient if:</p> <ul style="list-style-type: none"> (a) the patient has a clinic blood pressure measurement (using a sphygmomanometer or a validated oscillometric blood pressure monitoring device) of either or both of the following measurements: <ul style="list-style-type: none"> (i) systolic blood pressure greater than or equal to 140 mmHg and less than or equal to 180 mmHg; (ii) diastolic blood pressure greater than or equal to 90 mmHg and less than or equal to 110 mmHg; and (b) the patient has not commenced anti-hypertensive therapy; and (c) the recording includes the patient’s resting blood pressure; and (d) the recording is conducted using microprocessor-based analysis equipment; and (e) the recording is interpreted by a medical practitioner and a report is prepared by the same medical practitioner; and (f) a treatment plan is provided for the patient; and (g) the service: <ul style="list-style-type: none"> (i) is not provided in association with ambulatory electrocardiogram recording, and (ii) is not associated with a service to which any of the following items apply: <ul style="list-style-type: none"> (A) 177; (B) 224 to 228; (C) 229 to 244; (D) 699;

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		5. VASCULAR
	(E) 701 to 707; (F) 715; (G) 721 to 732; (H) 735 to 758. Applicable only once in any 12 month period (See para DN.1.35 of explanatory notes to this Category) Fee: \$112.80 Benefit: 75% = \$84.60 85% = \$95.90	
Fee 11610	MEASUREMENT OF ANKLE: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of lower extremity arterial disease, examination, hard copy trace and report. Fee: \$69.75 Benefit: 75% = \$52.35 85% = \$59.30	
Fee 11611	MEASUREMENT OF WRIST: BRACHIAL INDICES AND ARTERIAL WAVEFORM ANALYSIS, measurement of radial and ulnar (or finger) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of the wrist (or finger) brachial systolic pressure indices and assessment of arterial waveforms for the evaluation of upper extremity arterial disease, examination, hard copy trace and report. Fee: \$69.75 Benefit: 75% = \$52.35 85% = \$59.30	
Fee 11612	EXERCISE STUDY FOR THE EVALUATION OF LOWER EXTREMITY ARTERIAL DISEASE, measurement of posterior tibial and dorsalis pedis (or toe) and brachial arterial pressures bilaterally using Doppler or plethysmographic techniques, the calculation of ankle (or toe) brachial systolic pressure indices for the evaluation of lower extremity arterial disease at rest and following exercise using a treadmill or bicycle ergometer or other such equipment where the exercise workload is quantifiably documented, examination and report. Fee: \$123.10 Benefit: 75% = \$92.35 85% = \$104.65	
Fee 11614	Transcranial doppler, examination of the intracranial arterial circulation using CW Doppler or pulsed Doppler with hard copy recording of waveforms, examination and report, other than a service associated with a service to which item 55280 of the diagnostic imaging services table applies Fee: \$82.90 Benefit: 75% = \$62.20 85% = \$70.50	
Fee 11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing. Fee: \$83.10 Benefit: 75% = \$62.35 85% = \$70.65	
Fee 11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a patient under 12 years of age Fee: \$250.40 Benefit: 75% = \$187.80 85% = \$212.85	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		6. CARDIOVASCULAR
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 6. Cardiovascular	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

6. CARDIOVASCULAR

<p>Fee 11704</p>	<p>Twelve-lead electrocardiography, trace and formal report, by a specialist or a consultant physician, if the service:</p> <p>(a) is requested by a requesting practitioner; and</p> <p>(b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies.</p> <p>Note: the following are also requirements of the service:</p> <ul style="list-style-type: none"> i. a formal report is completed; and ii. a copy of the formal report is provided to the requesting practitioner; and iii. the service is not provided to the patient as part of an episode of hospital treatment or hospital-substitute treatment; and iv. is not provided in association with an attendance item (Part 2 of the schedule); and v. the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner. <p>(See para DN.1.31, DR.1.4 of explanatory notes to this Category)</p> <p>Fee: \$34.25 Benefit: 85% = \$29.15 Extended Medicare Safety Net Cap: \$25.80</p>
<p>Fee 11705</p>	<p>Twelve-lead electrocardiography, formal report only, by a specialist or a consultant physician, if the service:</p> <p>(a) is requested by a requesting practitioner; and</p> <p>(b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable not more than twice on the same day</p> <p>Note: the following are also requirements of the service:</p> <ul style="list-style-type: none"> i. a formal report is completed; and ii. a copy of the formal report is provided to the requesting practitioner; and iii. the specialist or consultant physician who renders the service does not have a financial relationship with the requesting practitioner. <p>(See para DN.1.31, DR.1.4 of explanatory notes to this Category)</p> <p>Fee: \$20.15 Benefit: 75% = \$15.15 85% = \$17.15</p>
<p>Fee 11707</p>	<p>Twelve-lead electrocardiography, trace only, by a medical practitioner, if:</p> <p>(a) the trace:</p> <ul style="list-style-type: none"> (i) is required to inform clinical decision making; and (ii) is reviewed in a clinically appropriate timeframe to identify potentially serious or life-threatening abnormalities; and (iii) does not need to be fully interpreted or reported on; and

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	6. CARDIOVASCULAR
	<p>(b) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable not more than twice on the same day</p> <p>Note: the service is not provided to the patient as part of an episode of:</p> <ul style="list-style-type: none"> i. hospital treatment; or ii. hospital-substitute treatment. <p>(See para DR.1.4 of explanatory notes to this Category)</p> <p>Fee: \$20.15 Benefit: 85% = \$17.15</p>
<p>Fee 11713</p>	<p>SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician</p> <p>Fee: \$76.35 Benefit: 75% = \$57.30 85% = \$64.90</p>
<p>Fee 11714</p>	<p>Twelve-lead electrocardiography, trace and clinical note, by a specialist or consultant physician, if the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable not more than twice on the same day</p> <p>Note: the service is not provided to the patient as part of an episode of:</p> <ul style="list-style-type: none"> i. hospital treatment; or ii. hospital-substitute treatment. <p>(See para DR.1.4 of explanatory notes to this Category)</p> <p>Fee: \$26.50 Benefit: 85% = \$22.55</p>
<p>Fee 11716</p>	<p>Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1</p> <p>Continuous ambulatory electrocardiogram recording for 12 or more hours, by a specialist or consultant physician, if the service:</p> <p>(a) is indicated for the evaluation of any of the following:</p> <ul style="list-style-type: none"> (i) syncope; (ii) pre-syncopal episodes; (iii) palpitations where episodes are occurring more than once a week; (iv) another asymptomatic arrhythmia is suspected with an expected frequency of greater than once a week; (v) surveillance following cardiac surgical procedures that have an established risk of causing dysrhythmia; and <p>(b) utilises a system capable of superimposition and full disclosure printout of at least 12 hours of recorded electrocardiogram data (including resting electrocardiogram and the recording of parameters) and microprocessor based scanning analysis; and</p> <p>(c) includes interpretation and report; and</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

6. CARDIOVASCULAR

	<p>(d) is not provided in association with ambulatory blood pressure monitoring; and</p> <p>(e) is not associated with a service to which item 11704, 11705, 11707, 11714, 11717, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable only once in any 4 week period</p> <p>Note: this services does not apply if the patient is being provided with the service as part of an episode of:</p> <ul style="list-style-type: none"> i. hospital treatment; or ii. hospital-substitute treatment. <p>(See para DN.1.28, DR.1.1 of explanatory notes to this Category) Fee: \$183.50 Benefit: 85% = \$156.00</p>
<p>Fee 11717</p>	<p>Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1</p> <p>Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service:</p> <p>(a) utilises a patient activated, single or multiple event memory recording device that:</p> <ul style="list-style-type: none"> (i) is connected continuously to the patient for between 7 and 30 days; and (ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and <p>(b) includes transmission, analysis, interpretation and reporting (including the indication for the investigation); and</p> <p>(c) is for the investigation of recurrent episodes of:</p> <ul style="list-style-type: none"> i. unexplained syncope; or ii. palpitation; or iii. other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and <p>(d) is not associated with a service to which item 11716, 11723, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable only once in any 3 month period</p> <p>Note: the service does not apply if the patient is being provided with the service as part of an episode of:</p> <ul style="list-style-type: none"> i. hospital treatment; or ii. hospital-substitute treatment. <p>(See para DN.1.26, DR.1.1 of explanatory notes to this Category) Fee: \$107.80 Benefit: 85% = \$91.65</p>
<p>Fee 11719</p>	<p>IMPLANTED PACEMAKER (including cardiac resynchronisation pacemaker) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least one remote review is provided in a 12 month period.</p>

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	<p>Payable only once in any 12 month period</p> <p>Fee: \$73.15 Benefit: 75% = \$54.90 85% = \$62.20</p>
Fee 11720	<p>IMPLANTED PACEMAKER TESTING, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus including reprogramming when required, not being a service associated with a service to which item 11721 applies.</p> <p>Fee: \$73.15 Benefit: 75% = \$54.90 85% = \$62.20</p>
Fee 11721	<p>IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11704, 11719, 11720, 11725 or 11726 applies</p> <p>(See para DN.1.33, DN.1.34 of explanatory notes to this Category)</p> <p>Fee: \$76.35 Benefit: 75% = \$57.30 85% = \$64.90</p>
Fee 11723	<p>Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1</p> <p>Ambulatory electrocardiogram monitoring, by a specialist or consultant physician, if the service:</p> <p>(a) utilises a patient activated, single or multiple event recording, on a memory recording device that:</p> <p style="padding-left: 40px;">(i) is connected continuously to the patient for up to 7 days; and</p> <p style="padding-left: 40px;">(ii) is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation; and</p> <p>(b) includes transmission, analysis, interpretation and formal report (including the indication for the investigation); and</p> <p>(c) is for the investigation of recurrent episodes of:</p> <p style="padding-left: 40px;">(i) unexplained syncope; or</p> <p style="padding-left: 40px;">(ii) palpitation; or</p> <p style="padding-left: 40px;">(iii) other symptoms where a cardiac rhythm disturbance is suspected and where infrequent episodes have occurred; and</p> <p>(d) is not associated with a service to which item 11716, 11717, 11735, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable only once in any 3 month period</p> <p>Note: The service does not apply if the patient is an admitted patient.</p> <p>(See para DN.1.26, DR.1.1 of explanatory notes to this Category)</p> <p>Fee: \$56.90 Benefit: 85% = \$48.40</p>
Fee 11724	<p>UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator</p> <p>Fee: \$184.95 Benefit: 75% = \$138.75 85% = \$157.25</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	6. CARDIOVASCULAR
Fee 11725	<p>IMPLANTED DEFIBRILLATOR (including cardiac resynchronisation defibrillator) REMOTE MONITORING involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period.</p> <p>Payable only once in any 12 month period</p> <p>Fee: \$207.55 Benefit: 75% = \$155.70 85% = \$176.45</p>
Fee 11726	<p>IMPLANTED DEFIBRILLATOR TESTING with patient attendance following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies.</p> <p>Fee: \$103.80 Benefit: 75% = \$77.85 85% = \$88.25</p>
Fee 11727	<p>IMPLANTED DEFIBRILLATOR TESTING involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, not being a service associated with a service to which item 11719, 11720, 11721, 11725 or 11726 applies</p> <p>(See para DN.1.34 of explanatory notes to this Category)</p> <p>Fee: \$103.80 Benefit: 75% = \$77.85 85% = \$88.25</p>
Fee 11728	<p>Implanted loop recording for the investigation of atrial fibrillation if the patient to whom the service is provided has been diagnosed as having had an embolic stroke of undetermined source, including reprogramming when required, retrieval of stored data, analysis, interpretation and report, other than a service to which item 38288 applies</p> <p>For any particular patient—applicable not more than 4 times in any 12 months</p> <p>Fee: \$38.05 Benefit: 75% = \$28.55 85% = \$32.35</p>
Fee 11729	<p>Note: the service only applies if the patient meets the requirements of the descriptor and the requirements in note DR.1.2</p> <p>Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, if:</p> <p>(a) the patient is 17 years or more; and</p> <p>(b) the patient:</p> <p style="padding-left: 40px;">(i) has symptoms consistent with cardiac ischemia; or</p> <p style="padding-left: 40px;">(ii) has other cardiac disease which may be exacerbated by exercise; or</p> <p style="padding-left: 40px;">(iii) has a first degree relative with suspected heritable arrhythmia; and</p> <p>(c) the monitoring and recording:</p> <p style="padding-left: 40px;">(i) is not less than 20 minutes; and</p> <p style="padding-left: 40px;">(ii) includes resting electrocardiogram; and</p> <p>(d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

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	<p>(e) the service is not a service:</p> <ul style="list-style-type: none"> (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61311, 61324, 61329, 61332, 61345, 61349, 61357, 61365, 61377, 61380, 61394, 61398, 61406, 61410, 61414 or 61418 applies <p>Applicable only once in any 24 month period</p> <p>(See para DN.1.29, DR.1.2 of explanatory notes to this Category) Fee: \$166.70 Benefit: 75% = \$125.05 85% = \$141.70</p>
<p>Fee 11730</p>	<p>Note: the service only applies if the patient meets the requirements of the descriptor and the requirements in note DR.1.3</p> <p>Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), if:</p> <ul style="list-style-type: none"> (a) the patient is less than 17 years; and (b) the patient: <ul style="list-style-type: none"> (i) has symptoms consistent with cardiac ischemia; or (ii) has other cardiac disease which may be exacerbated by exercise; or (iii) has a first degree relative with suspected heritable arrhythmia; and (c) the monitoring and recording: <ul style="list-style-type: none"> (i) is not less than 20 minutes in duration; and (ii) includes resting electrocardiogram; and (d) a written report is produced by a medical practitioner that includes interpretation of the monitoring and recording data, commenting on the significance of the data, and the relationship of the data to clinical decision making for the patient in the clinical context; and (e) the service is not a service: <ul style="list-style-type: none"> (i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or (ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61311, 61324, 61329, 61332, 61345, 61349, 61357, 61365, 61377, 61380, 61394, 61398, 61406, 61410, 61414 or 61418 applies <p>Applicable only once in any 24 month period</p> <p>(See para DN.1.30, DR.1.3 of explanatory notes to this Category)</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS **6. CARDIOVASCULAR**

	<p>Fee: \$166.70 Benefit: 75% = \$125.05 85% = \$141.70</p>
	<p>Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming (if required), retrieval of stored data, analysis, interpretation and report, if the service is:</p> <p>(a) an investigation for a patient with:</p> <p style="padding-left: 40px;">(i) cryptogenic stroke; or</p> <p style="padding-left: 40px;">(ii) recurrent unexplained syncope; and</p> <p>(b) not a service to which item 38285 applies</p> <p>Applicable only once in any 4 week period</p>
Fee 11731	<p>(See para DN.1.27 of explanatory notes to this Category)</p> <p>Fee: \$38.05 Benefit: 75% = \$28.55 85% = \$32.35</p>
	<p>Note: the service only applies if the patient meets one or more of the following and the requirements in Note: DR.1.1</p> <p>Continuous ambulatory electrocardiogram recording for 7 days, by a specialist or consultant physician, if the service:</p> <p>(a) utilises intelligent microprocessor based monitoring, with patient triggered recording and symptom reporting capability, real time analysis of electrocardiograms and alerts and daily or live data uploads; and</p> <p>(b) is for the investigation of:</p> <p style="padding-left: 40px;">(i) episodes of suspected intermittent cardiac arrhythmia or episodes of syncope; or</p> <p style="padding-left: 40px;">(ii) suspected intermittent cardiac arrhythmia in a patient who has had a previous cerebrovascular accident, is at risk of cerebrovascular accident or has had one or more previous transient ischemic attacks; and</p> <p>(c) includes interpretation and report; and</p> <p>(d) is not a service:</p> <p style="padding-left: 40px;">(i) provided in association with ambulatory blood pressure monitoring; or</p> <p style="padding-left: 40px;">(ii) associated with a service to which item 11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</p> <p>Applicable not more than 4 times in any 12 month period</p> <p>Note: The service does not apply if the patient is an admitted patient.</p>
Fee 11735	<p>(See para DN.1.26, DR.1.1 of explanatory notes to this Category)</p> <p>Fee: \$140.10 Benefit: 85% = \$119.10</p>
Fee 11736	<p>Implanted loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), for the investigation of atrial fibrillation, if the service:</p> <p>(a) is provided to a patient who has been diagnosed as having had an embolic stroke of undetermined source; and</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		6. CARDIOVASCULAR
	(b) is not a service to which item 38288 applies Applicable not more than 4 times in any 12 month period Fee: \$38.05 Benefit: 75% = \$28.55 85% = \$32.35	
Fee 11737	Implanted electrocardiogram loop recording via remote monitoring (including reprogramming (if required), retrieval of stored data, analysis, interpretation and report), by a medical practitioner, if the service is: (a) an investigation for a patient with: (i) cryptogenic stroke; or (ii) recurrent unexplained syncope; and (b) not a service to which item 38285 applies Applicable only once in any 4 week period Fee: \$38.05 Benefit: 75% = \$28.55 85% = \$32.35	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		7. GASTROENTEROLOGY & COLORECTAL
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 7. Gastroenterology & Colorectal	
Fee 11800	OESOPHAGEAL MOTILITY TEST, manometric Fee: \$191.05 Benefit: 75% = \$143.30 85% = \$162.40	
Fee 11801	CLINICAL ASSESSMENT OF GASTRO-OESOPHAGEAL REFLUX DISEASE that involves 48 hour catheter-free wireless ambulatory oesophageal pH monitoring including administration of the device and associated endoscopy procedure for placement, analysis and interpretation of the data and all attendances for providing the service, if (a) a catheter-based ambulatory oesophageal pH-monitoring: (i) has been attempted on the patient but failed due to clinical complications, or (ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and (b) the services is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy. Not in association with another item in Category 2, sub-group 7 (Anaes.) Fee: \$288.05 Benefit: 75% = \$216.05 85% = \$244.85	
Fee 11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation Fee: \$191.05 Benefit: 75% = \$143.30 85% = \$162.40	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	7. GASTROENTEROLOGY & COLORECTAL
<p>Fee 11820</p>	<p>Capsule endoscopy to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if:</p> <p>(a) the service is provided to a patient who:</p> <p style="padding-left: 40px;">(i) has overt gastrointestinal bleeding; or</p> <p style="padding-left: 40px;">(ii) has gastrointestinal bleeding that is recurrent or persistent, and iron deficiency anaemia that is not due to coeliac disease, and, if the patient also has menorrhagia, has had the menorrhagia considered and managed; and</p> <p>(b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and</p> <p>(c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and</p> <p>(d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and</p> <p>(e) the service is not associated with a service to which item 30680, 30682, 30684 or 30686 applies</p> <p>(See para DN.1.15 of explanatory notes to this Category) Fee: \$1,346.40 Benefit: 75% = \$1009.80 85% = \$1253.20</p>
<p>Fee 11823</p>	<p>Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if:</p> <p>(a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and</p> <p>(b) the item is performed only once in any 2 year period; and</p> <p>(c) the service is not associated with balloon enteroscopy.</p> <p>(See para DN.1.15 of explanatory notes to this Category) Fee: \$1,346.40 Benefit: 75% = \$1009.80 85% = \$1253.20</p>
<p>Fee 11830</p>	<p>DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex</p> <p>Fee: \$204.60 Benefit: 75% = \$153.45 85% = \$173.95</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	7. GASTROENTEROLOGY & COLORECTAL
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Fee 11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency Fee: \$273.50 Benefit: 75% = \$205.15 85% = \$232.50
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D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	8. GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
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	Group D1. Miscellaneous Diagnostic Procedures And Investigations
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	Subgroup 8. Genito/Urinary Physiological Investigations
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Fee 11900	Urine flow study, including peak urine flow measurement, not being a service associated with a service to which item 11912, 11917 or 11919 applies Fee: \$30.15 Benefit: 75% = \$22.65 85% = \$25.65
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Fee 11912	Cystometrography: (a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and (b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible; not being a service associated with a service to which any of items 11012 to 11027, 11900, 11917, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.) Fee: \$216.30 Benefit: 75% = \$162.25 85% = \$183.90
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Fee 11917	Cystometrography, in conjunction with real time ultrasound of one or more components of the urinary tract: (a) with measurement of any one or more of the following: (i) urine flow rate; (ii) urethral pressure profile; (iii) urethral sphincter electromyography; and (b) with simultaneous measurement of: (i) rectal pressure; or (ii) stomal or vaginal pressure if rectal pressure is not possible; including all imaging associated with cystometrography, not being a service associated with a service to which any of items 11012 to 11027, 11900, 11912, 11919 and 36800 or an item in Group I3 of the diagnostic imaging services table applies (Anaes.) Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85
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Fee 11919	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any one or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography, being a service associated with a service to which items 60506 or 60509 applies; other than a service associated with a service to which items 11012-11027, 11900-11917 and 36800 apply (Anaes.) Fee: \$469.20 Benefit: 75% = \$351.90 85% = \$398.85
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D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	9. ALLERGY TESTING
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	Group D1. Miscellaneous Diagnostic Procedures And Investigations
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	Subgroup 9. Allergy Testing
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D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		9. ALLERGY TESTING
Fee 12000	<p>Skin prick testing for aeroallergens by a specialist or consultant physician in the practice of the specialist or consultant physician's specialty, including all allergens tested on the same day, not being a service associated with a service to which item 12001, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies</p> <p>(See para DN.1.22 of explanatory notes to this Category) Fee: \$42.65 Benefit: 75% = \$32.00 85% = \$36.30</p>	
Fee 12001	<p>Skin prick testing for aeroallergens, including all allergens tested on the same day, not being a service associated with a service to which item 12000, 12002, 12005, 12012, 12017, 12021, 12022 or 12024 applies.</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.22 of explanatory notes to this Category) Fee: \$42.65 Benefit: 75% = \$32.00 85% = \$36.30</p>	
Fee 12002	<p>Repeat skin prick testing of a patient for aeroallergens, including all allergens tested on the same day, if:</p> <p>(a) further testing for aeroallergens is indicated in the same 12 month period to which item 12001 applies to a service for the patient; and</p> <p>(b) the service is not associated with a service to which item 12000, 12001, 12005, 12012, 12017, 12021, 12022 or 12024 applies</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.22 of explanatory notes to this Category) Fee: \$42.65 Benefit: 75% = \$32.00 85% = \$36.30</p>	
Fee 12003	<p>Skin prick testing for food and latex allergens, including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies</p> <p>(See para DN.1.22 of explanatory notes to this Category) Fee: \$42.65 Benefit: 75% = \$32.00 85% = \$36.30</p>	
Fee 12004	<p>Skin testing for medication allergens (antibiotics or non general anaesthetics agents) and venoms (including prick testing and intradermal testing with a number of dilutions), including all allergens tested on the same day, not being a service associated with a service to which item 12012, 12017, 12021, 12022 or 12024 applies</p> <p>(See para DN.1.22 of explanatory notes to this Category) Fee: \$64.50 Benefit: 75% = \$48.40 85% = \$54.85</p>	
Fee 12005	<p>Skin testing:</p> <p>(a) performed by or on behalf of a specialist or consultant physician in the practice of the specialist or consultant physician's specialty; and</p> <p>(b) for agents used in the perioperative period (including prick testing and intradermal testing with a number of dilutions), to investigate anaphylaxis in a patient with a history of prior anaphylactic reaction or cardiovascular collapse associated with the administration of an anaesthetic; and</p> <p>(c) including all allergens tested on the same day; and</p> <p>(d) not being a service associated with a service to which item 12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies</p> <p>(See para DN.1.22 of explanatory notes to this Category) Fee: \$86.70 Benefit: 75% = \$65.05 85% = \$73.70</p>	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		9. ALLERGY TESTING
Fee 12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens Fee: \$22.80 Benefit: 75% = \$17.10 85% = \$19.40	
Fee 12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens Fee: \$76.90 Benefit: 75% = \$57.70 85% = \$65.40	
Fee 12021	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 50 allergens but not more than 75 allergens Fee: \$126.45 Benefit: 75% = \$94.85 85% = \$107.50	
Fee 12022	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 75 allergens but not more than 100 allergens Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25	
Fee 12024	Epicutaneous patch testing in the investigation of allergic dermatitis, performed by or on behalf of a specialist, or consultant physician, in the practice of his or her specialty, using more than 100 allergens Fee: \$169.20 Benefit: 75% = \$126.90 85% = \$143.85	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	Group D1. Miscellaneous Diagnostic Procedures And Investigations	
	Subgroup 10. Other Diagnostic Procedures And Investigations	
Fee 12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis Fee: \$40.70 Benefit: 75% = \$30.55 85% = \$34.60	
Fee 12201	Administration, by a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: (a) the patient has had a total thyroidectomy and 1 ablative dose of radioactive iodine; and (b) the patient is maintained on thyroid hormone therapy; and (c) the patient is at risk of recurrence; and (d) on at least 1 previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy, the patient did not have evidence of well-differentiated thyroid cancer; and (e) either: (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contra-indicated because the patient has: (a) unstable coronary artery disease; or (b) hypopituitarism; or (c) a high risk of relapse or exacerbation of a previous severe psychiatric illness applicable once only in a 12 month period (See para DN.1.16 of explanatory notes to this Category) Fee: \$2,620.75 Benefit: 75% = \$1965.60 85% = \$2527.55	
Fee 12203	Overnight diagnostic assessment of sleep, for at least 8 hours, for a patient aged 18 years or more, to confirm diagnosis of a sleep disorder, if: (a) either: (i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP-Bang	

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

	<p>score of 3 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or</p> <p>(ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that assessment is necessary to confirm the diagnosis of a sleep disorder; and</p> <p>(b) the overnight diagnostic assessment is performed to investigate:</p> <p>(i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study; or</p> <p>(ii) suspected central sleep apnoea syndrome; or</p> <p>(iii) suspected sleep hypoventilation syndrome; or</p> <p>(iv) suspected sleep-related breathing disorders in association with non-respiratory co-morbid conditions including heart failure, significant cardiac arrhythmias, neurological disease, acromegaly or hypothyroidism; or</p> <p>(v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or</p> <p>(vi) suspected parasomnia or seizure disorder where clinical diagnosis cannot be established on clinical features alone (including associated atypical features, vigilance behaviours or failure to respond to conventional therapy); or</p> <p>(vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and</p> <p>(c) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:</p> <p>(i) airflow;</p> <p>(ii) continuous EMG;</p> <p>(iii) anterior tibial EMG;</p> <p>(iv) continuous ECG;</p> <p>(v) continuous EEG;</p> <p>(vi) EOG;</p> <p>(vii) oxygen saturation;</p> <p>(viii) respiratory movement (chest and abdomen);</p> <p>(ix) position; and</p> <p>(e) polygraphic records are:</p>
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	<p>(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service described in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category) Fee: \$644.00 Benefit: 75% = \$483.00 85% = \$550.80</p>
Fee 12204	<p>Overnight assessment of positive airway pressure, for at least 8 hours, for a patient aged 18 years or more, if:</p> <p>(a) the necessity for an intervention sleep study is determined by a qualified adult sleep medicine practitioner or consultant respiratory physician where a diagnosis of a sleep-related breathing disorder has been made; and</p> <p>(b) the patient has not undergone positive airway pressure therapy in the previous 6 months; and</p> <p>(c) following professional attendance on the patient by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), the qualified adult sleep medicine practitioner or consultant respiratory physician establishes that the sleep-related breathing disorder is responsible for the patient's symptoms; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(e) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:</p> <ul style="list-style-type: none"> (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement; (ix) position; and

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	<p>(f) polygraphic records are:</p> <ul style="list-style-type: none"> (i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and <p>(g) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(h) the overnight assessment is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category) Fee: \$644.00 Benefit: 75% = \$483.00 85% = \$550.80</p>
<p>Fee 12205</p>	<p>Follow-up study for a patient aged 18 years or more with a sleep-related breathing disorder, following professional attendance on the patient by a qualified adult sleep medicine practitioner or consultant respiratory physician (either face-to-face or by video conference), if:</p> <p>(a) any of the following subparagraphs applies:</p> <ul style="list-style-type: none"> (i) there has been a recurrence of symptoms not explained by known or identifiable factors such as inadequate usage of treatment, sleep duration or significant recent illness; (ii) there has been a significant change in weight or changes in co-morbid conditions that could affect sleep-related breathing disorders, and other means of assessing treatment efficacy (including review of data stored by a therapy device used by the patient) are unavailable or have been equivocal; (iii) the patient has undergone a therapeutic intervention (including, but not limited to, positive airway pressure, upper airway surgery, positional therapy, appropriate oral appliance, weight loss of more than 10% in the previous 6 months or oxygen therapy), and there is either clinical evidence of sub-optimal response or uncertainty about control of sleep-disordered breathing; and <p>(b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:</p> <ul style="list-style-type: none"> (i) airflow; (ii) continuous EMG; (iii) anterior tibial EMG; (iv) continuous ECG; (v) continuous EEG;

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	<p>(vi) EOG;</p> <p>(vii) oxygen saturation;</p> <p>(viii) respiratory movement (chest and abdomen);</p> <p>(ix) position; and</p> <p>(d) polygraphic records are:</p> <p>(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of a report; and</p> <p>(e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(f) the follow-up study is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category)</p> <p>Fee: \$644.00 Benefit: 75% = \$483.00 85% = \$550.80</p>
<p>Fee 12207</p>	<p>Overnight investigation, for a patient aged 18 years or more, for a sleep-related breathing disorder, following professional attendance by a qualified adult sleep medicine practitioner or a consultant respiratory physician (either face-to-face or by video conference), if:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and</p> <p>(c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures:</p> <p>(i) airflow;</p> <p>(ii) continuous EMG;</p> <p>(iii) anterior tibial EMG;</p> <p>(iv) continuous ECG;</p> <p>(v) continuous EEG;</p> <p>(vi) EOG;</p> <p>(vii) oxygen saturation;</p> <p>(viii) respiratory movement (chest and abdomen)</p>

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	<p>(ix) position; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 40px;">(i) analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 40px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient; and</p> <p>(h) previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and</p> <p>(i) if the patient has severe respiratory failure—a further investigation is indicated in the same 12 month period to which items 12204 and 12205 apply to a service for the patient, for the adjustment or testing, or both, of the effectiveness of a positive pressure ventilatory support device (other than continuous positive airway pressure) in sleep</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category)</p> <p>Fee: \$644.00 Benefit: 75% = \$483.00 85% = \$550.80</p>
Fee 12208	<p>Overnight investigation, for sleep apnoea for at least 8 hours, for a patient aged 18 years or more, if:</p> <p>(a) a qualified adult sleep medicine practitioner or consultant respiratory physician has determined that the investigation is necessary to confirm the diagnosis of a sleep disorder; and</p> <p>(b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures:</p> <p style="padding-left: 40px;">(i) airflow;</p> <p style="padding-left: 40px;">(ii) continuous EMG;</p> <p style="padding-left: 40px;">(iii) anterior tibial EMG;</p> <p style="padding-left: 40px;">(iv) continuous ECG;</p> <p style="padding-left: 40px;">(v) continuous EEG;</p> <p style="padding-left: 40px;">(vi) EOG;</p>

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	<p>(vii) oxygen saturation;</p> <p>(viii) respiratory movement (chest and abdomen);</p> <p>(ix) position; and</p> <p>(d) polygraphic records are:</p> <p style="padding-left: 20px;">(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 20px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(e) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(f) a further investigation is indicated in the same 12 month period to which item 12203 applies to a service for the patient because insufficient sleep was acquired, as evidenced by a sleep efficiency of 25% or less, during the previous investigation to which that item applied; and</p> <p>(g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category)</p> <p>Fee: \$644.00 Benefit: 75% = \$483.00 85% = \$550.80</p>
Fee 12210	<p>Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and</p> <p>(c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines:</p> <p style="padding-left: 20px;">(i) airflow;</p> <p style="padding-left: 20px;">(ii) continuous EMG;</p> <p style="padding-left: 20px;">(iii) ECG;</p> <p style="padding-left: 20px;">(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p style="padding-left: 20px;">(v) EOG;</p> <p style="padding-left: 20px;">(vi) oxygen saturation;</p> <p style="padding-left: 20px;">(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p>

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	<p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <ul style="list-style-type: none"> (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and (ii) stored for interpretation and preparation of a report; and <p>(f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and</p> <p>(g) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient</p> <p>For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category) Fee: \$768.70 Benefit: 75% = \$576.55 85% = \$675.50</p>
Fee 12213	<p>Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p> <p>(c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines:</p> <ul style="list-style-type: none"> (i) airflow; (ii) continuous EMG; (iii) ECG; (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads); (v) EOG; (vi) oxygen saturation; (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen); (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and

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(d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and

(e) polygraphic records are:

- (i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and
- (ii) stored for interpretation and preparation of a report; and

(f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and

(g) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient

For each particular patient—applicable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period

(See para DN.1.17 of explanatory notes to this Category)
Fee: \$692.50 **Benefit:** 75% = \$519.40 85% = \$599.30

Overnight paediatric investigation, for at least 8 hours, for a patient less than 12 years of age, if:

(a) the patient is referred by a medical practitioner; and

(b) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner before the investigation; and

(c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines:

- (i) airflow;
- (ii) continuous EMG;
- (iii) ECG;
- (iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);
- (v) EOG;
- (vi) oxygen saturation;
- (vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);
- (viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and

(d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and

(e) polygraphic records are:

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	<p>(i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and report are provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and</p> <p>(g) a further investigation is indicated in the same 12 month period to which item 12210 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances:</p> <p>(i) there is ongoing hypoxia or hypoventilation on the third study to which item 12210 applied for the patient, and further titration of respiratory support is needed to optimise therapy;</p> <p>(ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12210 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and</p> <p>(h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient</p> <p>Applicable only once in the same 12 month period to which item 12210 applies</p> <p>(See para DN.1.17 of explanatory notes to this Category) Fee: \$768.70 Benefit: 75% = \$576.55 85% = \$675.50</p>
<p>Fee 12217</p>	<p>Overnight paediatric investigation, for at least 8 hours, for a patient aged at least 12 years but less than 18 years, if:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the necessity for the investigation is determined by a qualified sleep medicine practitioner before the investigation; and</p> <p>(c) there is continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following are made, in accordance with current professional guidelines:</p> <p>(i) airflow;</p> <p>(ii) continuous EMG;</p> <p>(iii) ECG;</p> <p>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p>

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	<p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(d) a sleep technician, or registered nurse with sleep technology training, is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 20px;">(i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 20px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and report are provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and</p> <p>(g) a further investigation is indicated in the same 12 month period to which item 12213 applies to a service for the patient, for a patient using Continuous Positive Airway Pressure (CPAP) or non-invasive or invasive ventilation, or supplemental oxygen, in either or both of the following circumstances:</p> <p style="padding-left: 20px;">(i) there is ongoing hypoxia or hypoventilation on the third study to which item 12213 applied for the patient, and further titration is needed to optimise therapy;</p> <p style="padding-left: 20px;">(ii) there is clear and significant change in clinical status (for example lung function or functional status) or an intervening treatment that may affect ventilation in the period since the third study to which item 12213 applied for the patient, and repeat study is therefore required to determine the need for or the adequacy of respiratory support; and</p> <p>(h) the investigation is not provided to the patient on the same occasion that a service to which item 11704, 11705, 11707, 11714, 11716, 11717, 11723 or 11735 applies is provided to the patient</p> <p>Applicable only once in the same 12 month period to which item 12213 applies</p> <p>(See para DN.1.17 of explanatory notes to this Category) Fee: \$692.50 Benefit: 75% = \$519.40 85% = \$599.30</p>
Fee 12250	<p>Overnight investigation of sleep for at least 8 hours of a patient aged 18 years or more to confirm diagnosis of obstructive sleep apnoea, if:</p> <p>(a) either:</p> <p style="padding-left: 20px;">(i) the patient has been referred by a medical practitioner to a qualified adult sleep medicine practitioner or a consultant respiratory physician who has determined that the patient has a high probability for symptomatic, moderate to severe obstructive sleep apnoea based on a STOP-Bang score of 3 or more, an OSA50 score of 5 or more or a high risk score on the Berlin Questionnaire, and an Epworth Sleepiness Scale score of 8 or more; or</p> <p style="padding-left: 20px;">(ii) following professional attendance on the patient (either face-to-face or by video conference) by a qualified adult sleep medicine practitioner or a consultant respiratory physician, the qualified adult sleep medicine practitioner or consultant respiratory physician determines that investigation is necessary to confirm the diagnosis of obstructive sleep apnoea; and</p> <p>(b) during a period of sleep, there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:</p>

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	<p>(i) airflow;</p> <p>(ii) continuous EMG;</p> <p>(iii) continuous ECG;</p> <p>(iv) continuous EEG;</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory effort; and</p> <p>(c) the investigation is performed under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(d) either:</p> <p>(i) the equipment is applied to the patient by a sleep technician; or</p> <p>(ii) if this is not possible—the reason it is not possible for the sleep technician to apply the equipment to the patient is documented and the patient is given instructions on how to apply the equipment by a sleep technician supported by written instructions; and</p> <p>(e) polygraphic records are:</p> <p>(i) analysed (for assessment of sleep stage, arousals, respiratory events and cardiac abnormalities) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the investigation is not provided to the patient on the same occasion that a service mentioned in any of items 11000, 11003, 11004, 11005, 11503, 11704, 11705, 11707, 11714, 11716, 11717, 11723, 11735 and 12203 is provided to the patient</p> <p>Applicable only once in any 12 month period</p> <p>(See para DN.1.17 of explanatory notes to this Category)</p> <p>Fee: \$367.20 Benefit: 75% = \$275.40 85% = \$312.15</p>
<p>Fee 12254</p>	<p>Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged 18 years or more, if:</p> <p>(a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and</p> <p>(b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures:</p>

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	<p>(i) airflow;</p> <p>(ii) continuous EMG;</p> <p>(iii) anterior tibial EMG;</p> <p>(iv) continuous ECG;</p> <p>(v) continuous EEG;</p> <p>(vi) EOG;</p> <p>(vii) oxygen saturation;</p> <p>(viii) respiratory movement (chest and abdomen);</p> <p>(ix) position; and</p> <p>(c) immediately following the overnight investigation a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 40px;">(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 40px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12258 is provided to the patient</p> <p>Applicable only once in a 12 month period</p> <p>(See para DN.1.23 of explanatory notes to this Category)</p> <p>Fee: \$1,000.65 Benefit: 75% = \$750.50 85% = \$907.45</p>
<p>Fee 12258</p>	<p>Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged 18 years or more, if:</p> <p>(a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to objectively confirm the ability to maintain wakefulness; and</p> <p>(b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring and recording, in accordance with current professional guidelines, of the following measures:</p> <p style="padding-left: 40px;">(i) airflow;</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

	<p>(ii) continuous EMG;</p> <p>(iii) anterior tibial EMG;</p> <p>(iv) continuous ECG;</p> <p>(v) continuous EEG;</p> <p>(vi) EOG;</p> <p>(vii) oxygen saturation;</p> <p>(viii) respiratory movement (chest and abdomen);</p> <p>(ix) position; and</p> <p>(c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 40px;">(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 40px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified adult sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12203, 12204, 12205, 12208, 12250 or 12254 is provided to the patient</p> <p>Applicable only once in a 12 month period</p> <p>(See para DN.1.23 of explanatory notes to this Category)</p> <p>Fee: \$1,000.65 Benefit: 75% = \$750.50 85% = \$907.45</p>
<p>Fee 12261</p>	<p>Multiple sleep latency test for the assessment of unexplained hypersomnolence in a patient aged at least 12 years but less than 18 years, if:</p> <p>(a) a qualified sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and</p> <p>(b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines:</p> <p style="padding-left: 40px;">(i) airflow;</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

	<p>(ii) continuous EMG;</p> <p>(iii) ECG;</p> <p>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p> <p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 40px;">(i) analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 40px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12265 is provided to the patient</p> <p>Applicable only once in a 12 month period</p> <p>(See para DN.1.23 of explanatory notes to this Category)</p> <p>Fee: \$1,049.25 Benefit: 75% = \$786.95 85% = \$956.05</p>
<p>Fee 12265</p>	<p>Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged at least 12 years but less than 18 years, if:</p> <p>(a) a qualified sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and</p> <p>(b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines:</p> <p style="padding-left: 40px;">(i) airflow;</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

	<p>(ii) continuous EMG;</p> <p>(iii) ECG;</p> <p>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p> <p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 40px;">(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 40px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12213, 12217 or 12261 is provided to the patient</p> <p>Applicable only once in a 12 month period</p> <p>(See para DN.1.23 of explanatory notes to this Category)</p> <p>Fee: \$1,049.25 Benefit: 75% = \$786.95 85% = \$956.05</p>
<p>Fee 12268</p>	<p>Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if:</p> <p>(a) a qualified paediatric sleep medicine practitioner determines that testing is necessary to confirm the diagnosis of a central disorder of hypersomnolence or to determine whether the eligibility criteria under the pharmaceutical benefits scheme for drugs relevant to treat that condition are met; and</p> <p>(b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines:</p> <p style="padding-left: 40px;">(i) airflow;</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

	<p>(ii) continuous EMG;</p> <p>(iii) ECG;</p> <p>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p> <p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 nap periods are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p style="padding-left: 40px;">(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p style="padding-left: 40px;">(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12272 is provided to the patient</p> <p>Applicable only once in a 12 month period</p> <p>(See para DN.1.23 of explanatory notes to this Category)</p> <p>Fee: \$1,125.40 Benefit: 75% = \$844.05 85% = \$1032.20</p>
<p>Fee 12272</p>	<p>Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if:</p> <p>(a) a qualified paediatric sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and</p> <p>(b) an overnight diagnostic assessment of sleep is performed for at least 8 hours, with continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of the following, in accordance with current professional guidelines:</p> <p style="padding-left: 40px;">(i) airflow;</p> <p style="padding-left: 40px;">(ii) continuous EMG;</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	<p>(iii) ECG;</p> <p>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p>(v) EOG;</p> <p>(vi) oxygen saturation;</p> <p>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p> <p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(c) immediately following the overnight investigation, a daytime investigation is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EEG, EMG, EOG and ECG; and</p> <p>(d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and</p> <p>(e) polygraphic records are:</p> <p>(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute; and</p> <p>(ii) stored for interpretation and preparation of a report; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and</p> <p>(g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or 12268 is provided to the patient</p> <p>Applicable only once in a 12 month period</p> <p>(See para DN.1.23 of explanatory notes to this Category) Fee: \$1,125.40 Benefit: 75% = \$844.05 85% = \$1032.20</p>
Fee 12306	<p>Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting), for:</p> <p>(a) confirmation of a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; or</p> <p>(b) monitoring of low bone mineral density proven by bone densitometry at least 12 months previously; other than a service associated with a service to which item 12312, 12315 or 12321 applies</p> <p>For any particular patient, once only in a 24 month period</p> <p>(See para DN.1.18 of explanatory notes to this Category) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

<p>Fee 12312</p>	<p>Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following:</p> <ul style="list-style-type: none"> (a) prolonged glucocorticoid therapy; (b) any condition associated with excess glucocorticoid secretion; (c) male hypogonadism; (d) female hypogonadism lasting more than 6 months before the age of 45; <p>other than a service associated with a service to which item 12306, 12315 or 12321 applies</p> <p>For any particular patient, once only in a 12 month period</p> <p>(See para DN.1.18 of explanatory notes to this Category) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35</p>
<p>Fee 12315</p>	<p>Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting) for diagnosis and monitoring of bone loss associated with one or more of the following conditions:</p> <ul style="list-style-type: none"> (a) primary hyperparathyroidism; (b) chronic liver disease; (c) chronic renal disease; (d) any proven malabsorptive disorder; (e) rheumatoid arthritis; (f) any condition associated with thyroxine excess; <p>other than a service associated with a service to which item 12306, 12312 or 12321 applies</p> <p>For any particular patient, once only in a 24 month period</p> <p>(See para DN.1.18 of explanatory notes to this Category) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35</p>
<p>Fee 12320</p>	<p>Bone densitometry, using dual energy X-ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if:</p> <ul style="list-style-type: none"> (a) the patient is 70 years of age or over, and (b) either: <ul style="list-style-type: none"> (i) the patient has not previously had bone densitometry; or (ii) the t-score for the patient's bone mineral density is -1.5 or more; <p>other than a service associated with a service to which item 12306, 12312, 12315, 12321 or 12322 applies</p> <p>For any particular patient, once only in a 5 year period</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	<p>(See para DN.1.18 of explanatory notes to this Category) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35</p>
Fee 12321	<p>Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites at least 12 months after a significant change in therapy (including interpretation and reporting), for:</p> <p>(a) established low bone mineral density; or</p> <p>(b) confirming a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma;</p> <p>other than a service associated with a service to which item 12306, 12312 or 12315 applies</p> <p>For any particular patient, once only in a 12 month period</p> <p>(See para DN.1.18 of explanatory notes to this Category) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35</p>
Fee 12322	<p>Bone densitometry, using dual energy X-ray absorptiometry or quantitative computed tomography, involving the measurement of 2 or more sites (including interpretation and reporting) for measurement of bone mineral density, if:</p> <p>(a) the patient is 70 years of age or over; and</p> <p>(b) the t-score for the patient's bone mineral density is less than -1.5 but more than -2.5;</p> <p>other than a service associated with a service to which item 12306, 12312, 12315, 12320 or 12321 applies</p> <p>For any particular patient, once only in a 2 year period</p> <p>(See para DN.1.18 of explanatory notes to this Category) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35</p>
Fee 12325	<p>Assessment of visual acuity and bilateral retinal photography with a non mydriatic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if:</p> <p>(a) the patient is of Aboriginal and Torres Strait Islander descent; and</p> <p>(b) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing</p> <p style="padding-left: 40px;">the primary glycaemic management of the patient's diabetes; and</p> <p>(c) this item and item 12326 have not applied to the patient in the preceding 12 months; and</p> <p>(d) the patient does not have:</p> <p style="padding-left: 40px;">(i) an existing diagnosis of diabetic retinopathy; or</p> <p style="padding-left: 40px;">(ii) visual acuity of less than 6/12 in either eye; or</p> <p style="padding-left: 40px;">(iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation</p> <p>(See para DN.1.19 of explanatory notes to this Category)</p>

D1. MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	10. OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	Fee: \$54.75 Benefit: 75% = \$41.10 85% = \$46.55
	<p>Assessment of visual acuity and bilateral retinal photography with a non-mydratic retinal camera, including analysis and reporting of the images for initial or repeat assessment for presence or absence of diabetic retinopathy, in a patient with medically diagnosed diabetes, if:</p> <p>(a) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing</p> <p style="padding-left: 40px;">the primary glycaemic management of the patient's diabetes; and</p> <p>(b) this item and item 12325 have not applied to the patient in the preceding 24 months; and</p> <p>(c) the patient does not have:</p> <p style="padding-left: 40px;">(i) an existing diagnosis of diabetic retinopathy; or</p> <p style="padding-left: 40px;">(ii) visual acuity of less than 6/12 in either eye; or</p> <p style="padding-left: 40px;">(iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation</p>
Fee 12326	(See para DN.1.19 of explanatory notes to this Category) Fee: \$54.75 Benefit: 75% = \$41.10 85% = \$46.55

D2. NUCLEAR MEDICINE (NON-IMAGING)	
	Group D2. Nuclear Medicine (Non-Imaging)
Fee 12500	BLOOD VOLUME ESTIMATION Fee: \$237.25 Benefit: 75% = \$177.95 85% = \$201.70
Fee 12524	RENAL FUNCTION TEST (without imaging procedure) Fee: \$173.45 Benefit: 75% = \$130.10 85% = \$147.45
Fee 12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) Fee: \$93.05 Benefit: 75% = \$69.80 85% = \$79.10
Fee 12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}\text{CO}_2$ or $^{14}\text{CO}_2$, for either: - (a)the confirmation of Helicobacter pylori colonisation, OR (b)the monitoring of the success of eradication of Helicobacter pylori in patients with peptic ulcer disease. not being a service to which 66900 applies Fee: \$92.70 Benefit: 75% = \$69.55 85% = \$78.80