



# Health Insurance (General Medical Services Table) Regulations 2021

made under the

*Health Insurance Act 1973*

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Volume 2: Schedule 1 (clauses 5.1.1–7.1.1)  
Endnotes

Each volume has its own contents

Prepared by the Office of Parliamentary Counsel, Canberra

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## About this compilation

### This compilation

This is a compilation of the *Health Insurance (General Medical Services Table) Regulations 2021* that shows the text of the law as amended and in force on 1 July 2024 (the *compilation date*).

The notes at the end of this compilation (the *endnotes*) include information about amending laws and the amendment history of provisions of the compiled law.

### Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. Any uncommenced amendments affecting the law are accessible on the Register ([www.legislation.gov.au](http://www.legislation.gov.au)). The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. For more information on any uncommenced amendments, see the Register for the compiled law.

### Application, saving and transitional provisions for provisions and amendments

If the operation of a provision or amendment of the compiled law is affected by an application, saving or transitional provision that is not included in this compilation, details are included in the endnotes.

### Editorial changes

For more information about any editorial changes made in this compilation, see the endnotes.

### Modifications

If the compiled law is modified by another law, the compiled law operates as modified but the modification does not amend the text of the law. Accordingly, this compilation does not show the text of the compiled law as modified. For more information on any modifications, see the Register for the compiled law.

### Self-repealing provisions

If a provision of the compiled law has been repealed in accordance with a provision of the law, details are included in the endnotes.

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**1 Name**

This instrument is the *Health Insurance (General Medical Services Table) Regulations 2021*.

**3 Authority**

This instrument is made under the *Health Insurance Act 1973*.

**4 General medical services table**

For the purposes of subsection 4(1) of the *Health Insurance Act 1973*, Schedule 1 is prescribed as a table of medical services.

## Schedule 1—General medical services table

Note: See section 4.

### Part 1—Preliminary

#### Division 1.1—Interpretation

##### 1.1.1 Dictionary

The Dictionary in Part 7 defines certain words and expressions that are used in this Schedule, and includes references to certain words and expressions that are defined elsewhere in this Schedule.

##### 1.1.2 Meaning of *eligible non-vocationally recognised medical practitioner*

(1) In this Schedule:

*eligible non-vocationally recognised medical practitioner* means:

(a) a medical practitioner:

- (i) who is registered under the MedicarePlus for Other Medical Practitioners Program; and
- (ii) who successfully completed the requirements of that Program, as evidenced by written advice from the Chief Executive Medicare; or

Note: The MedicarePlus for Other Medical Practitioners Program will cease on 31 December 2023.

(b) a medical practitioner who:

- (i) as at 30 June 2023, was registered under:
  - (A) the After Hours Other Medical Practitioners Program; or
  - (B) the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program; or
  - (C) the Rural Other Medical Practitioners' Program; and
- (ii) is registered under, and providing general medical services in accordance with, the Other Medical Practitioners Extension Program; or

(c) a medical practitioner:

- (i) who is registered as a medical practitioner under the MedicarePlus for Other Medical Practitioners Program; and
- (ii) providing general medical services in accordance with that Program.

Note: The MedicarePlus for Other Medical Practitioners Program will cease on 31 December 2023.

(2) In subclause (1):

*After Hours Other Medical Practitioners Program* means the program by that name that, before 1 July 2023, was administered by the Chief Executive Medicare.

**MedicarePlus for Other Medical Practitioners Program** means the program by that name administered by the Chief Executive Medicare that, for medical services provided in accordance with the Program, provides a particular level of medicare benefits.

**Other Medical Practitioners Extension Program** means the program by that name administered by the Chief Executive Medicare that, for medical services provided in accordance with the Program, provides a particular level of medicare benefits.

**Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program** means the program by that name that, before 1 July 2023, was administered by the Chief Executive Medicare.

**Rural Other Medical Practitioners' Program** means the program by that name that, before 1 July 2023, was administered by the Chief Executive Medicare.

Note 1: The After Hours Other Medical Practitioners Program, the Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program and the Rural Other Medical Practitioners' Program ceased on 30 June 2023.

Note 2: The MedicarePlus for Other Medical Practitioners Program will cease on 31 December 2023.

### 1.1.3 General practitioners

For the purposes of paragraph (b) of the definition of **general practitioner** in subsection 3(1) of the Act, the following medical practitioners are specified:

- (a) a medical practitioner who is undertaking a placement in general practice that is approved by the Royal Australian College of General Practitioners (the **RACGP**):
  - (i) as part of a training program for general practice leading to the award of Fellowship of the RACGP; or
  - (ii) as part of another training program recognised by the RACGP as being of an equivalent standard;
- (b) an eligible non-vocationally recognised medical practitioner;
- (c) a medical practitioner who is undertaking a placement in general practice as part of the Remote Vocational Training Scheme administered by Remote Vocational Training Scheme Limited;
- (d) a medical practitioner who is undertaking a placement in general practice that is approved by the Australian College of Rural and Remote Medicine (the **ACRRM**):
  - (i) as part of a training program for general practice leading to the award of Fellowship of the ACRRM; or
  - (ii) as part of another training program recognised by the ACRRM as being of an equivalent standard.

Note: For other medical practitioners who are general practitioners, see the definition of **general practitioner** in subsection 3(1) of the Act and section 16 of the *Health Insurance Regulations 2018*.

Clause 1.1.4

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### 1.1.4 Meaning of multidisciplinary case conference

In this Schedule:

***multidisciplinary case conference*** means a process by which a multidisciplinary case conference team carries out all of the following activities:

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

### 1.1.5 Meaning of multidisciplinary case conference team

- (1) In this Schedule, a ***multidisciplinary case conference team*** for a patient:
  - (a) includes a medical practitioner; and
  - (b) either:
    - (i) for items 235, 236, 237, 238, 239, 240, 735 to 758, 825 to 828, 930, 933, 935, 937, 943, 945, 946, 948, 959, 961, 962, 964, 969, 971, 972, 973, 975, 986, 6029 to 6042 and 6064 to 6075—includes at least 2 other members; or
    - (ii) for an item mentioned in subclause (3)—includes at least 3 other members; and
  - (c) may also include a family member of the patient.
- (2) For the members mentioned in paragraph (b):
  - (a) each member must provide a different kind of care or service to the patient; and
  - (b) each member must not be an unpaid carer of the patient; and
  - (c) one member may be another medical practitioner.

Example: Other members may be allied health professionals, home and community service providers and care organisers, including the following:

- (a) Aboriginal and Torres Strait Islander health practitioners;
- (b) asthma educators;
- (c) audiologists;
- (d) dental therapists;
- (e) dentists;
- (f) diabetes educators;
- (g) dieticians;
- (h) mental health workers;
- (i) occupational therapists;
- (j) optometrists;
- (k) orthoptists;
- (l) orthotists or prosthetists;

- (m) pharmacists;
- (n) physiotherapists;
- (o) podiatrists;
- (p) psychologists;
- (q) registered nurses;
- (r) social workers;
- (s) speech pathologists;
- (t) education providers;
- (u) “meals on wheels” providers;
- (v) personal care workers;
- (w) probation officers.

- (3) For the purposes of subparagraph (1)(b)(ii), the items are items 820, 822, 823, 830, 832, 834, 2946, 2949, 2954, 2978, 2984, 2988, 3032, 3040, 3044, 3069 and 3074.

### 1.1.6 Meaning of single course of treatment

- (1) Use this clause for items 104 to 133, 385 to 388, 2801 to 2840, 3005 to 3028, 6007 to 6015, 6018, 6019, 6024, 6051, 6052, 6058, 6062, 6063, 16401, 16404, 16406, 51700 and 51703.
- (2) A **single course of treatment** for a patient:
- (a) includes:
    - (i) the initial attendance on the patient by a specialist or consultant physician; and
    - (ii) the continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and
    - (iii) any subsequent review of the patient’s condition by the specialist or consultant physician that may be necessary, whether the review is initiated by the referring practitioner or by the specialist or consultant physician; but
  - (b) does not include:
    - (i) referral of the patient to the specialist or consultant physician; or
    - (ii) an attendance (the **later attendance**) on the patient by the specialist or consultant physician, after the end of the period of validity of the last referral to have application under section 102 of the *Health Insurance Regulations 2018* if:
      - (A) the referring practitioner considers the later attendance necessary for the patient’s condition to be reviewed; and
      - (B) the patient was most recently attended by the specialist or consultant physician more than 9 months before the later attendance.

Note: Division 4 of Part 11 of the *Health Insurance Regulations 2018* prescribes the manner in which patients are to be referred when an item in this Schedule specifies a service that is to be rendered by a specialist or consultant physician to a patient who has been referred.

Clause 1.1.7

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### 1.1.7 Meaning of symbol (H)

An item in this Schedule including the symbol (**H**) applies only to a service performed or provided in a hospital.

### 1.1.8 References in this Schedule to items include items determined under section 3C of the Act

A reference in this Schedule to an item includes a reference to an item relating to a health service that, under a determination in force under subsection 3C(1) of the Act, is treated as if there were an item in the table that relates to the service.

## Division 1.2—General application provisions

### 1.2.1 Application

An item in this Schedule does not apply to a service provided in contravention of a law of the Commonwealth, a State or Territory.

### 1.2.2 Restrictions on certain items—attendances by specialists and consultant physicians without referrals

- (1) Use this clause for items 104 to 111, 115 to 137, 141 to 147, 289 to 388, 2801 to 2840, 3005 to 3028, 6007 to 6015, 6018 to 6028, 6051 to 6063, 16401, 16404, 16407, 16408, 16508, 16509, 16533, 16534, 17640 to 17655, 90260, 90261, 90266 and 90267.
- (2) The item does not apply to an attendance on a patient by a specialist or consultant physician if:
  - (a) the attendance forms part of a single course of treatment for the patient; and
  - (b) the attendance is after the end of the period of validity (under section 102 of the *Health Insurance Regulations 2018*) of the referral that was valid for the initial attendance on the patient by the specialist or consultant physician in the single course of treatment; and
  - (c) the attendance is not within the period of validity (under section 102 of the *Health Insurance Regulations 2018*) of a later referral.

Note: Division 4 of Part 11 of the *Health Insurance Regulations 2018* prescribes the manner in which patients are to be referred when an item in this Schedule specifies a service that is to be rendered by a specialist or consultant physician to a patient who has been referred.

### 1.2.3 Restrictions on certain items—attendances by specialist radiologists in conjunction with certain diagnostic imaging services

- (1) Use this clause for items 52, 53, 54, 57, 104, 105 and 151.
- (2) The item does not apply to an attendance on a patient by a specialist in the specialty of diagnostic radiology if the attendance is in association with a service

to which any of the following items of the diagnostic imaging services table applies:

- (a) an item in Subgroup 6 of Group I1;
  - (b) an item in any of Subgroups 1 to 7 of Group I3;
  - (c) items 58900 and 58903 in Subgroup 8 of Group I3;
  - (d) item 59103 in Subgroup 9 of Group I3.
- (3) The item also does not apply to an attendance on a patient if the attendance is in association with a service to which an item in Group I5 of the diagnostic imaging services table applies, unless the practitioner providing the service considers the attendance is necessary for the management or treatment of the patient.

#### **1.2.4 Restrictions on certain items—attendances by specialists and consultant physicians on same day as they perform certain surgical operations**

- (1) Use this clause for items 105, 116, 119, 386, 2806, 2814, 3010, 3014, 6009 to 6015, 6019, 6052, 16404, 91823, 91825, 91826, 91833, 91836, 92611, 92612, 92613 and 92618.

Note: Some of these items are specified in determinations made under subsection 3C(1) of the Act.

- (2) The item does not apply to a service if:
- (a) the service is an attendance on a patient by a specialist or a consultant physician on the same day as the day on which an operation is performed on the patient by the specialist or consultant physician; and
  - (b) the operation is a service to which an item in Group T8 applies; and
  - (c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$341.75 or more.

#### **1.2.5 Professional attendance services—matters included**

- (1) Use this clause for items 3 to 338, 348 to 388, 410 to 417, 585 to 600, 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 792, 900, 903, 969, 971, 972, 973, 975, 986, 2497 to 2840, 3005 to 3028, 5000 to 5267, 6007 to 6015, 6018 to 6024, 6051 to 6063, 13899, 16401, 16404, 16406, 16407, 16508, 16509, 16533, 16534, 17610 to 17690, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278.
- (2) A professional attendance includes the provision, for a patient, of any of the following services:
- (a) evaluating the patient's condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19(5) of the Act;
  - (b) formulating a plan for the management and, if applicable, for the treatment of the patient's condition or conditions;
  - (c) giving advice to the patient about the patient's condition or conditions and, if applicable, about treatment;

Clause 1.2.6

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- (d) if authorised by the patient—giving advice to another person, or other persons, about the patient’s condition or conditions and, if applicable, about treatment;
  - (e) providing appropriate preventive health care;
  - (f) recording the clinical details of the service or services provided to the patient.
- (3) However, a professional attendance does not include the supply of a vaccine to a patient if:
- (a) the vaccine is supplied to the patient in connection with a professional attendance mentioned in any of items 3 to 65, 123, 124, 151, 165, 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 5000 to 5267 and 90020 to 90098; and
  - (b) the cost of the vaccine is not subsidised by the Commonwealth or a State.

**1.2.6 Personal attendance by medical practitioners generally—application and matters included**

- (1) Use this clause for items 3 to 147, 151, 165, 177, 179, 181, 185, 187, 189, 191, 193 to 338, 348 to 417, 585 to 600, 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 792, 2497 to 2840, 3005 to 3028, 35570, 35571, 35573, 35577, 35581, 35582, 35585, 4001 to 6015, 6018 to 6024, 6051 to 6058, 6062, 6063, 10801 to 10816, 11012 to 11021, 11304, 11600, 11627, 11705, 11724, 11731, 12000 to 12004, 12201, 13030 to 13104, 13106 to 13110, 13209, 13290 to 13700, 13815 to 13899, 14100 to 14124, 14203 to 14212, 14216, 14219, 14224, 14255 to 14288, 15942, 15944, 15946, 15948, 16003 to 16512, 16515 to 51318, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278.
- (2) The item applies to a service provided in the course of a personal attendance by a single medical practitioner on a single patient on a single occasion.
- (3) A personal attendance by the medical practitioner on the patient includes any of the following:
- (a) the planning, management and supervision of the patient on home dialysis to which item 13104 applies;
  - (b) participating in a video conferencing consultation referred to in item 294.

**1.2.7 Personal attendance by medical practitioners—application and matters included**

- (1) Use this clause for items 3 to 230, 233, 245 to 723, 732, 733, 737, 741, 745, 761, 763, 766, 769, 772, 776, 788, 789, 792, 900, 903, 2700 to 6015, 6018 to 6024, 6028, 6051 to 6058, 6062, 6063, 10801 to 10816, 11012 to 11021, 11304, 11600, 11627, 11705, 11724, 11728, 11731, 11820, 11823, 12000, 12003, 12004, 12201, 13030 to 13104, 13106 to 13110, 13209, 13290 to 13700, 13815 to 13899, 14100 to 14124, 14203 to 14212, 14216, 14219, 14224, 14255 to 14288, 15942, 15944, 15946, 15948, 16003 to 16512, 16515 to 51318, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278.

- (2) The item applies to a service provided during a personal attendance by:
  - (a) a medical practitioner (other than a medical practitioner employed by the proprietor of a hospital that is not a private hospital); or
  - (b) a medical practitioner who:
    - (i) is employed by the proprietor of a hospital that is not a private hospital; and
    - (ii) provides the service otherwise than in the course of employment by that proprietor.
- (3) Subclause (2) applies whether or not another person provides essential assistance to the medical practitioner in accordance with accepted medical practice.
- (4) A personal attendance by the medical practitioner on the patient includes any of the following:
  - (a) the planning, management and supervision of the patient on home dialysis to which item 13104 applies;
  - (b) participating in a video conferencing consultation referred to in item 294.

### **1.2.8 Restriction on items—services provided with non-medicare services**

Items 3 to 10816, 90020 to 90096, 90098, 90183, 90188, 90202, 90212, 90215 and 90250 to 90278 do not apply to a service described in the item if the service is provided at the same time as, or in connection with, a non-medicare service.

### **1.2.9 Restrictions on items—services rendered in certain circumstances or for certain purposes**

An item in this Schedule does not apply to a service described in the item if the service is rendered in any of the following circumstances:

- (a) the service is rendered in relation to the provision of chelation therapy, in the form of the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts, otherwise than for the treatment of heavy-metal poisoning;
- (b) the service is rendered in association with the injection of human chorionic gonadotrophin in the management of obesity;
- (c) the service is rendered in relation to the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) the service is rendered for the purpose of, or in relation to, the removal of tattoos;
- (e) the service is rendered for the purposes of, or in relation to, the removal from a cadaver of kidneys for transplantation;
- (f) the service is rendered to a patient of a hospital for the purposes of, or in relation to:
  - (i) the transplantation of a thoracic or abdominal organ, other than a kidney, or of part of an organ of that kind; or

Clause 1.2.10

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- (ii) the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or of a part of an organ of that kind;
- (g) the service is rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used immediately before or during the therapy;
- (h) the service is rendered to a patient at the same time as, or in connection with, an injection of blood or a blood product that is autologous.

**1.2.10 Restriction on items—services provided with harvesting, storage, in vitro processing or injection of non-haematopoietic stem cells**

An item in this Schedule does not apply to a service described 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.

**1.2.11 Services that may be provided by persons other than medical practitioners**

- (1) Use this clause for items 10983 to 10989, 10997, 11000, 11003, 11004, 11005, 11009, 11024, 11027, 11200, 11203, 11204, 11205, 11210, 11211, 11215, 11218, 11221, 11224, 11235, 11237, 11240, 11241, 11242, 11243, 11244, 11300, 11302, 11303, 11306, 11309, 11312, 11315, 11318, 11324, 11332, 11340, 11341, 11342, 11343, 11345, 11503, 11505, 11506, 11507, 11508, 11512, 11602, 11604, 11605, 11607, 11610, 11611, 11612, 11614, 11615, 11704, 11707, 11713, 11714, 11716, 11717, 11721, 11723, 11725, 11726, 11727, 11729, 11730, 11732, 11735, 11800, 11810, 11830, 11833, 11900, 11912, 11919, 12012, 12017, 12021, 12022, 12024, 12200, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217, 12250 to 12272, 12500 to 12527, 13015, 13020, 13025, 13200 to 13203, 13212, 13215, 13218, 13221, 13703, 13706, 13750, 13755, 13757, 13760, 14050, 14217, 14218, 14220, 14221, 15900 to 15984, 16514 and 41764.
- (2) The item applies whether the medical service is given by:
  - (a) a medical practitioner; or
  - (b) a person, other than a medical practitioner, who:
    - (i) is employed by a medical practitioner; or
    - (ii) in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

**1.2.12 Restriction on items—services involving video conferences between patients and medical practitioners separated by at least 15 km**

If it is a condition of a service, in an item, involving a video conference between a patient and a medical practitioner that the patient and practitioner be at least 15 km by road from one another, the item does not apply if the patient or the practitioner travels to ensure that the condition is met.

Note: This clause has effect whether the condition is set out in the item or not.

### **1.2.13 Restriction on items—attendances on same day as electrocardiogram services are performed**

- (1) An item in Part 2 of this Schedule does not apply to a service (the *attendance service*) provided by a specialist, consultant physician or medical practitioner to a patient on a day if an electrocardiogram service to which item 11716, 11717, 11723, 11729, 11732 or 11735 applies is provided by the specialist, consultant physician or medical practitioner to the patient on the same day.
- (2) Subclause (1) does not apply if:
  - (a) the patient has been referred to the specialist, consultant physician or medical practitioner; or
  - (b) the patient is being provided with ongoing care by the specialist, consultant physician or medical practitioner; or
  - (c) both of the following apply:
    - (i) another medical practitioner has requested the electrocardiogram service;
    - (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.

### **1.2.14 Restriction on items—attendances on same day as echocardiogram services or myocardial perfusion study services are performed**

- (1) An item in Part 2 of this Schedule does not apply to a service (the *attendance service*) provided to a patient on a day if either of the following is provided to the patient on the same day:
  - (a) an echocardiogram service to which item 55126, 55127, 55128, 55129, 55132, 55133, 55134, 55137, 55141, 55143, 55145 or 55146 applies;
  - (b) a myocardial perfusion study service to which item 61321, 61324, 61325, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies.
- (2) Subclause (1) does not apply if:
  - (a) both:
    - (i) the attendance service is provided after another service is provided to the patient; and
    - (ii) clinical management decisions are made about the patient during that other service; or
  - (b) the decision to perform the echocardiogram service or the myocardial perfusion study service on the same day is made as a result of a clinical assessment of the patient during the attendance service.

## Division 1.3—Indexation of fees

### 1.3.1 Indexation—1 July 2024

- (1) At the start of 1 July 2024 (the *indexation time*), each amount covered by subclause (2) is replaced by the amount worked out using the following formula:

$1.035 \times$  the amount of the fee immediately before the indexation time

Note: The indexed fees could in 2024 be viewed on the Department's MBS Online website (<http://www.health.gov.au>).

- (2) The amounts covered by this subclause are the fee for each item in a Group in this Schedule, other than the fee for the following:
- (a) an item in Group A2;
  - (b) an item in Group A23;
  - (c) items 90092, 90093, 90095, 90096 and 90098 in Group A35;
  - (d) an item in Group T10.
- (3) To avoid doubt, a fee listed in any of the following items is not indexed under subclause (1):
- (a) items in a Group that list the fee as a percentage of a fee listed in another item in the Group;
  - (b) items in a Group that list the fee as an amount under a specified clause in this Schedule;
  - (c) a table item of the following tables:
    - (i) table 2.1.1;
    - (ii) table 2.1.2;
    - (iii) table 2.20.2;
    - (iv) table 2.20.2A.
- (4) An amount worked out under subclause (1) is to be rounded up or down to the nearest 5 cents (rounding down if the amount is an exact multiple of 2.5 cents).

## Part 2—Attendances

### Division 2.1—Preliminary

#### 2.1.1 Meaning of amount under clause 2.1.1

In an item of this Schedule mentioned in column 1 of table 2.1.1:

**amount under clause 2.1.1** means the sum of:

- (a) the fee mentioned in column 2 for the item; and
- (b) either:
  - (i) if a practitioner attends not more than 6 patients in a single attendance—the amount mentioned in column 3 for the item, divided by the number of patients attended; or
  - (ii) if a practitioner attends more than 6 patients in a single attendance—the amount mentioned in column 4 for the item.

**Table 2.1.1—Amount under clause 2.1.1**

Item	Column 1 Item of this Schedule	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) (\$)	Column 4 Amount if more than 6 patients (\$)
1	4	The fee for item 3	30.00	2.40
2	24	The fee for item 23	30.00	2.40
3	37	The fee for item 36	30.00	2.40
4	47	The fee for item 44	30.00	2.40
5	58	\$8.50	15.50	0.70
6	59	\$16.00	17.50	0.70
7	60	\$35.50	15.50	0.70
8	65	\$57.50	15.50	0.70
9	124	The fee for item 123	30.00	2.40
10	165	\$88.20	15.50	0.70
11	195	The fee for item 193	29.60	2.35
12	414	The fee for item 410	29.50	2.35
13	415	The fee for item 411	29.50	2.35
14	416	The fee for item 412	29.50	2.35
15	417	The fee for item 413	29.50	2.35
16	5003	The fee for item 5000	29.60	2.35
17	5010	The fee for item 5000	53.25	3.80

Schedule 1 General medical services table

Part 2 Attendances

Division 2.1 Preliminary

Clause 2.1.2

Table 2.1.1—Amount under clause 2.1.1

Item	Column 1 Item of this Schedule	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) (\$)	Column 4 Amount if more than 6 patients (\$)
18	5023	The fee for item 5020	29.60	2.35
19	5028	The fee for item 5020	53.25	3.80
20	5043	The fee for item 5040	29.60	2.35
21	5049	The fee for item 5040	53.25	3.80
22	5063	The fee for item 5060	29.60	2.35
23	5067	The fee for item 5060	53.25	3.80
24	5076	The fee for item 5071	29.60	2.35
25	5077	The fee for item 5071	53.25	3.80
26	5220	\$18.50	15.50	0.70
27	5223	\$26.00	17.50	0.70
28	5227	\$45.50	15.50	0.70
29	5228	\$67.50	15.50	0.70
30	5260	\$18.50	27.95	1.25
31	5261	\$112.20	15.50	0.70
32	5262	\$112.20	27.95	1.25
33	5263	\$26.00	31.55	1.25
34	5265	\$45.50	27.95	1.25
35	5267	\$67.50	27.95	1.25
36	90272	The fee for item 90271	29.60	2.35
37	90274	The fee for item 90273	29.60	2.35
38	90276	The fee for item 90275	23.65	1.85
39	90278	The fee for item 90277	23.65	1.85

2.1.2 Meaning of amount under clause 2.1.2

In an item of this Schedule mentioned in column 1 of table 2.1.2:

**amount under clause 2.1.2** means the sum of:

- (a) the fee mentioned in column 2 for the item; and
- (b) either:
  - (i) if a practitioner attends not more than 6 patients in a single attendance—the amount mentioned in column 3 for the item, divided by the number of patients attended; or

- (ii) if a practitioner attends more than 6 patients in a single attendance—the amount mentioned in column 4 for the item.

**Table 2.1.2—Amount under clause 2.1.2**

<b>Item</b>	<b>Column 1 Item of this Schedule</b>	<b>Column 2 Fee</b>	<b>Column 3 Amount if not more than 6 patients (to be divided by the number of patients) (\$)</b>	<b>Column 4 Amount if more than 6 patients (\$)</b>
1	181	The fee for item 179	24.00	1.90
2	187	The fee for item 185	24.00	1.90
3	191	The fee for item 189	24.00	1.90
4	206	The fee for item 203	24.00	1.90
5	303	The fee for item 301	24.00	1.90

## **Division 2.2—Group A1: General practitioner attendances to which no other item applies**

### **2.2.1 Items in Group A1**

This clause sets out items in Group A1.

Note: The fees in Group A1 are indexed in accordance with clause 1.3.1.

**Group A1—General practitioner attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
3	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	17.90
4	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
23	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan;	39.10

Schedule 1 General medical services table

Part 2 Attendances

Division 2.2 Group A1: General practitioner attendances to which no other item applies

Clause 2.2.1

<b>Group A1—General practitioner attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
24	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation— an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
36	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	75.75
37	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation— an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
44	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history;	111.50

<b>Group A1—General practitioner attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
47	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation— an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1
123	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation	191.20
124	Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health related issues, with appropriate documentation— an attendance on one or more patients at one place on one occasion—each patient	Amount under clause 2.1.1

Schedule 1 General medical services table

Part 2 Attendances

Division 2.3 Group A2: Other non-referred attendances to which no other item applies

Clause 2.3.1

**Division 2.3—Group A2: Other non-referred attendances to which no other item applies**

**2.3.1 Items in Group A2**

This clause sets out items in Group A2.

<b>Group A2—Other non-referred attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Other medical practitioner attendances</b>		
52	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	11.00
53	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	21.00
54	Professional attendance at consulting rooms lasting more than 25 minutes, but not more than 45 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	38.00
57	Professional attendance at consulting rooms lasting more than 45 minutes, but not more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	61.00
151	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item applies) by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	98.40
58	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies), lasting not more than 5 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1
59	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients at one place on one occasion—each patient, by:	Amount under clause 2.1.1

<b>Group A2—Other non-referred attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	
60	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1
65	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 45 minutes, but not more than 60 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1
165	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item in this Schedule applies) lasting more than 60 minutes—an attendance on one or more patients at one place on one occasion—each patient, by: (a) a medical practitioner who is not a general practitioner; or (b) a Group A1 disqualified general practitioner	Amount under clause 2.1.1

## **Division 2.4—Group A3: Specialist attendances to which no other item applies**

### **2.4.1 Items in Group A3**

This clause sets out items in Group A3.

Note: The fees in Group A3 are indexed in accordance with clause 1.3.1.

<b>Group A3—Specialist attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
104	Professional attendance at consulting rooms or hospital by a specialist in the practice of the specialist's specialty after referral of the patient to the specialist—initial attendance in a single course of treatment, other than a service to which item 106, 109 or 16401 applies	90.35
105	Professional attendance by a specialist in the practice of the specialist's	45.40

Schedule 1 General medical services table

Part 2 Attendances

Division 2.4 Group A3: Specialist attendances to which no other item applies

Clause 2.4.1

<b>Group A3—Specialist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	specialty following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, if that attendance is at consulting rooms or hospital, other than a service to which item 16404 applies	
106	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology and following referral of the patient to the specialist—an initial attendance at which the only service provided is refraction testing for the issue of a prescription for spectacles or contact lenses, if that attendance is at consulting rooms or hospital (other than a service to which any of items 104, 109 and 10801 to 10816 applies)	74.95
107	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist—an initial attendance, if that attendance is at a place other than consulting rooms or hospital	132.60
108	Professional attendance by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, if that attendance is at a place other than consulting rooms or hospital	83.95
109	Professional attendance by a specialist in the practice of the specialist's specialty of ophthalmology following referral of the patient to the specialist—an initial attendance at which a comprehensive eye examination, including pupil dilation, is performed on: (a) a patient aged 9 years or younger; or (b) a patient aged 14 years or younger with developmental delay; (other than a service to which any of items 104, 106 and 10801 to 10816 applies)	203.65
111	Professional attendance at consulting rooms or in hospital by a specialist in the practice of the specialist's specialty following referral of the patient to the specialist by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if: (a) during the attendance, the specialist determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the specialist subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$341.75 or more For any particular patient, once only on the same day	45.40
115	Professional attendance at consulting rooms or in hospital on a day by a medical practitioner (the <b>attending practitioner</b> ) who is a specialist or consultant physician in the practice of the attending practitioner's specialty after referral of the patient to the attending practitioner by a referring practitioner—an attendance after the initial attendance in a	45.40

**Group A3—Specialist attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	single course of treatment, if: <ul style="list-style-type: none"> <li>(a) the attending practitioner performs a scheduled operation on the patient on the same day; and</li> <li>(b) the operation is a service to which an item in Group T8 applies; and</li> <li>(c) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$341.75 or more; and</li> <li>(d) the attendance is unrelated to the scheduled operation; and</li> <li>(e) it is considered a clinical risk to defer the attendance to a later day</li> </ul> For any particular patient, once only on the same day	

**Division 2.5—Group A4: Consultant physician (other than psychiatry) attendances to which no other item applies****2.5.1 Items in Group A4**

This clause sets out items in Group A4.

Note: The fees in Group A4 are indexed in accordance with clause 1.3.1.

**Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
110	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—initial attendance in a single course of treatment	159.35
116	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—an attendance (other than a service to which item 119 applies) after the initial attendance in a single course of treatment	79.75
117	Professional attendance at consulting rooms or in hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—an attendance after the initial attendance in a single course of treatment, if: <ul style="list-style-type: none"> <li>(a) the attendance is not a minor attendance; and</li> <li>(b) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and</li> </ul>	79.75

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.5** Group A4: Consultant physician (other than psychiatry) attendances to which no other item applies

Clause 2.5.1

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**Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies**

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<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(c) the consultant physician subsequently performs the operation on the patient, on the same day; and (d) the operation is a service to which an item in Group T8 applies; and (e) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$341.75 or more For any particular patient, once only on the same day	
119	Professional attendance at consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—minor attendance	45.40
120	Professional attendance at consulting rooms or in hospital by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—minor attendance, if: (a) during the attendance, the consultant physician determines the need to perform an operation on the patient that had not otherwise been scheduled; and (b) the consultant physician subsequently performs the operation on the patient, on the same day; and (c) the operation is a service to which an item in Group T8 applies; and (d) the amount specified in the item in Group T8 as the fee for a service to which that item applies is \$341.75 or more For any particular patient, once only on the same day	45.40
122	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—initial attendance in a single course of treatment	193.35
128	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—an attendance (other than a service to which item 131 applies) after the initial attendance in a single course of treatment	116.95
131	Professional attendance at a place other than consulting rooms or hospital, by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) following referral of the patient to the consultant physician by a referring practitioner—minor attendance	84.25
132	Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 45 minutes for an initial assessment of a patient with at least 2 morbidities (which may include complex congenital, developmental and	278.75

**Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<p>behavioural disorders) following referral of the patient to the consultant physician by a referring practitioner, if:</p> <p>(a) an assessment is undertaken that covers:</p> <p style="padding-left: 20px;">(i) a comprehensive history, including psychosocial history and medication review; and</p> <p style="padding-left: 20px;">(ii) comprehensive multi or detailed single organ system assessment; and</p> <p style="padding-left: 20px;">(iii) the formulation of differential diagnoses; and</p> <p>(b) a consultant physician treatment and management plan of significant complexity is prepared and provided to the referring practitioner, which involves:</p> <p style="padding-left: 20px;">(i) an opinion on diagnosis and risk assessment; and</p> <p style="padding-left: 20px;">(ii) treatment options and decisions; and</p> <p style="padding-left: 20px;">(iii) medication recommendations; and</p> <p>(c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and</p> <p>(d) this item has not applied to an attendance on the patient in the preceding 12 months by the same consultant physician</p>	
133	<p>Professional attendance by a consultant physician in the practice of the consultant physician's specialty (other than psychiatry) lasting at least 20 minutes after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities (which may include complex congenital, developmental and behavioural disorders) if:</p> <p>(a) a review is undertaken that covers:</p> <p style="padding-left: 20px;">(i) review of initial presenting problems and results of diagnostic investigations; and</p> <p style="padding-left: 20px;">(ii) review of responses to treatment and medication plans initiated at time of initial consultation; and</p> <p style="padding-left: 20px;">(iii) comprehensive multi or detailed single organ system assessment; and</p> <p style="padding-left: 20px;">(iv) review of original and differential diagnoses; and</p> <p>(b) the modified consultant physician treatment and management plan is provided to the referring practitioner, which involves, if appropriate:</p> <p style="padding-left: 20px;">(i) a revised opinion on the diagnosis and risk assessment; and</p> <p style="padding-left: 20px;">(ii) treatment options and decisions; and</p> <p style="padding-left: 20px;">(iii) revised medication recommendations; and</p> <p>(c) an attendance on the patient to which item 110, 116 or 119 applies did not take place on the same day by the same consultant physician; and</p> <p>(d) item 132 applied to an attendance claimed in the preceding 12 months; and</p> <p>(e) the attendance under this item is claimed by the same consultant physician who claimed item 132 or a locum tenens; and</p>	139.55

Schedule 1 General medical services table

Part 2 Attendances

Division 2.6 Group A29: Attendance services for complex neurodevelopmental disorder or disability

Clause 2.6.1

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**Group A4—Consultant physician (other than psychiatry) attendances to which no other item applies**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
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(f) this item has not applied more than twice in any 12 month period

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## **Division 2.6—Group A29: Attendance services for complex neurodevelopmental disorder or disability**

### **2.6.1 Meaning of eligible disability**

In this Schedule:

**eligible disability** means any of the following:

- (a) sight impairment that results in vision of less than or equal to 6/18 vision or equivalent field loss in the better eye, with correction;
- (b) hearing impairment that results in:
  - (i) a hearing loss of 40 decibels or greater in the better ear, across 4 frequencies; or
  - (ii) permanent conductive hearing loss and auditory neuropathy;
- (c) deafblindness;
- (d) cerebral palsy;
- (e) Down syndrome;
- (f) Fragile X syndrome;
- (g) Prader-Willi syndrome;
- (h) Williams syndrome;
- (i) Angelman syndrome;
- (j) Kabuki syndrome;
- (k) Smith-Magenis syndrome;
- (l) CHARGE syndrome;
- (m) Cri du Chat syndrome;
- (n) Cornelia de Lange syndrome;
- (o) microcephaly, if a child has:
  - (i) a head circumference less than the third percentile for age and sex; and
  - (ii) a functional level at or below 2 standard deviations below the mean for age on a standard development test or an IQ score of less than 70 on a standardised test of intelligence;
- (p) Rett's disorder;
- (q) fetal alcohol spectrum disorder;
- (r) Lesch-Nyhan syndrome;
- (s) 22q deletion syndrome.

**2.6.2 Meaning of risk assessment**

In items 135, 137 and 139:

**risk assessment** means an assessment of:

- (a) the risk to the patient of a contributing co-morbidity; and
- (b) environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.

**2.6.3 Items in Group A29**

This clause sets out items in Group A29.

Note: The fees in Group A29 are indexed in accordance with clause 1.3.1.

<b>Group A29—Attendance services for complex neurodevelopmental disorder or disability</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
135	<p>Professional attendance lasting at least 45 minutes by a consultant physician in the practice of the consultant physician's specialty of paediatrics, following referral of the patient to the consultant paediatrician by a referring practitioner, for a patient aged under 25, if the consultant paediatrician:</p> <ul style="list-style-type: none"> <li>(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and</li> <li>(b) develops a treatment and management plan, which must include: <ul style="list-style-type: none"> <li>(i) documentation of the confirmed diagnosis; and</li> <li>(ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and</li> <li>(iii) a risk assessment; and</li> <li>(iv) treatment options (which may include biopsychosocial recommendations); and</li> </ul> </li> <li>(c) provides a copy of the treatment and management plan to: <ul style="list-style-type: none"> <li>(i) the referring practitioner; and</li> <li>(ii) one or more allied health providers, if appropriate, for the treatment of the patient;</li> </ul> </li> </ul> <p>(other than attendance on a patient for whom payment has previously been made under this item or item 137, 139, 289, 92140, 92141, 92142 or 92434)</p> <p>Applicable only once per lifetime</p>	278.75
137	<p>Professional attendance lasting at least 45 minutes by a specialist or consultant physician (not including a general practitioner), following referral of the patient to the specialist or consultant physician by a referring practitioner, for a patient aged under 25, if the specialist or consultant physician:</p>	278.75

Schedule 1 General medical services table

Part 2 Attendances

Division 2.6 Group A29: Attendance services for complex neurodevelopmental disorder or disability

Clause 2.6.3

**Group A29—Attendance services for complex neurodevelopmental disorder or disability**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<p>(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and</p> <p>(b) develops a treatment and management plan, which must include:</p> <ul style="list-style-type: none"><li>(i) documentation of the confirmed diagnosis; and</li><li>(ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and</li><li>(iii) a risk assessment; and</li><li>(iv) treatment options (which may include biopsychosocial recommendations); and</li></ul> <p>(c) provides a copy of the treatment and management plan to:</p> <ul style="list-style-type: none"><li>(i) the referring practitioner; and</li><li>(ii) one or more allied health providers, if appropriate, for the treatment of the patient;</li></ul> <p>(other than attendance on a patient for whom payment has previously been made under this item or item 135, 139, 289, 92140, 92141, 92142 or 92434)</p> <p>Applicable only once per lifetime</p>	
139	<p>Professional attendance lasting at least 45 minutes, at a place other than a hospital, by a general practitioner (not including a specialist or consultant physician), for a patient aged under 25, if the general practitioner:</p> <p>(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of an eligible disability is made (if appropriate, using information provided by an eligible allied health provider); and</p> <p>(b) develops a treatment and management plan, which must include:</p> <ul style="list-style-type: none"><li>(i) documentation of the confirmed diagnosis; and</li><li>(ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and</li><li>(iii) a risk assessment; and</li><li>(iv) treatment options (which may include biopsychosocial recommendations); and</li></ul> <p>(c) provides a copy of the treatment and management plan to one or more allied health providers, if appropriate, for the treatment of the patient;</p> <p>(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 289, 92140, 92141, 92142 or 92434)</p> <p>Applicable only once per lifetime</p>	139.95

## Division 2.7—Group A28: Geriatric medicine

### 2.7.1 Items in Group A28

This clause sets out items in Group A28.

Note: The fees in Group A28 are indexed in accordance with clause 1.3.1.

#### Group A28—Geriatric medicine

Column 1 Item	Column 2 Description	Column 3 Fee (\$)
141	<p>Professional attendance lasting more than 60 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician's or specialist's specialty of geriatric medicine, if:</p> <p>(a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and</p> <p>(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and</p> <p>(c) during the attendance:</p> <p style="margin-left: 20px;">(i) the medical, physical, psychological and social aspects of the patient's health are evaluated in detail using appropriately validated assessment tools if indicated (the <i>assessment</i>); and</p> <p style="margin-left: 20px;">(ii) the patient's various health problems and care needs are identified and prioritised (the <i>formulation</i>); and</p> <p style="margin-left: 20px;">(iii) a detailed management plan is prepared (the <i>management plan</i>) setting out:</p> <p style="margin-left: 40px;">(A) the prioritised list of health problems and care needs; and</p> <p style="margin-left: 40px;">(B) short and longer term management goals; and</p> <p style="margin-left: 40px;">(C) recommended actions or intervention strategies to be undertaken by the patient's general practitioner or another relevant health care provider that are likely to improve or maintain health status and are readily available and acceptable to the patient and the patient's family and carers; and</p> <p style="margin-left: 20px;">(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient's family and any carers; and</p> <p style="margin-left: 20px;">(v) the management plan is communicated in writing to the referring practitioner; and</p> <p>(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and</p> <p>(e) an attendance to which this item or item 145 applies has not been provided to the patient by the same practitioner in the preceding 12 months</p>	478.05

Schedule 1 General medical services table  
Part 2 Attendances  
Division 2.7 Group A28: Geriatric medicine

Clause 2.7.1

<b>Group A28—Geriatric medicine</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
143	Professional attendance lasting more than 30 minutes at consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician’s or specialist’s specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under item 141 or 145, if: <p>(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and</p> <p>(b) during the attendance:</p> <p>(i) the patient’s health status is reassessed; and</p> <p>(ii) a management plan prepared under item 141 or 145 is reviewed and revised; and</p> <p>(iii) the revised management plan is explained to the patient and (if appropriate) the patient’s family and any carers and communicated in writing to the referring practitioner; and</p> <p>(c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies was not provided to the patient on the same day by the same practitioner; and</p> <p>(d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and</p> <p>(e) an attendance to which this item or item 147 applies has not been provided to the patient in the preceding 12 months, unless there has been a significant change in the patient’s clinical condition or care circumstances that requires a further review</p>	298.85
145	Professional attendance lasting more than 60 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician’s or specialist’s specialty of geriatric medicine, if: <p>(a) the patient is at least 65 years old and referred by a medical practitioner practising in general practice (including a general practitioner, but not including a specialist or consultant physician) or a participating nurse practitioner; and</p> <p>(b) the attendance is initiated by the referring practitioner for the provision of a comprehensive assessment and management plan; and</p> <p>(c) during the attendance:</p> <p>(i) the medical, physical, psychological and social aspects of the patient’s health are evaluated in detail utilising appropriately validated assessment tools if indicated (the <b>assessment</b>); and</p> <p>(ii) the patient’s various health problems and care needs are identified and prioritised (the <b>formulation</b>); and</p> <p>(iii) a detailed management plan is prepared (the <b>management plan</b>) setting out:</p> <p>(A) the prioritised list of health problems and care needs; and</p> <p>(B) short and longer term management goals; and</p> <p>(C) recommended actions or intervention strategies, to be undertaken by the patient’s general practitioner or another relevant health care provider that are likely to improve or</p>	579.65

<b>Group A28—Geriatric medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p style="text-align: center;">maintain health status and are readily available and acceptable to the patient, the patient’s family and any carers; and</p> <p>(iv) the management plan is explained and discussed with the patient and, if appropriate, the patient’s family and any carers; and</p> <p>(v) the management plan is communicated in writing to the referring practitioner; and</p> <p>(d) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and</p> <p>(e) an attendance to which this item or item 141 applies has not been provided to the patient by the same practitioner in the preceding 12 months</p>	
147	<p>Professional attendance lasting more than 30 minutes at a place other than consulting rooms or hospital by a consultant physician or specialist in the practice of the consultant physician’s or specialist’s specialty of geriatric medicine to review a management plan previously prepared by that consultant physician or specialist under items 141 or 145, if:</p> <p>(a) the review is initiated by the referring medical practitioner practising in general practice or a participating nurse practitioner; and</p> <p>(b) during the attendance:</p> <p style="padding-left: 20px;">(i) the patient’s health status is reassessed; and</p> <p style="padding-left: 20px;">(ii) a management plan that was prepared under item 141 or 145 is reviewed and revised; and</p> <p style="padding-left: 20px;">(iii) the revised management plan is explained to the patient and (if appropriate) the patient’s family and any carers and communicated in writing to the referring practitioner; and</p> <p>(c) an attendance to which item 104, 105, 107, 108, 110, 116 or 119 applies has not been provided to the patient on the same day by the same practitioner; and</p> <p>(d) an attendance to which item 141 or 145 applies has been provided to the patient by the same practitioner in the preceding 12 months; and</p> <p>(e) an attendance to which this item or 143 applies has not been provided by the same practitioner in the preceding 12 months, unless there has been a significant change in the patient’s clinical condition or care circumstances that requires a further review</p>	362.35

Clause 2.8.1

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## Division 2.8—Group A5: Prolonged attendances to which no other item applies

### 2.8.1 Restrictions on items in Group A5

- (1) Items 160 to 164 apply only to a service provided in the course of a personal attendance by one or more general practitioners, specialists or consultant physicians on a single patient on a single occasion.
- (2) If the personal attendance is provided by one or more general practitioners, specialists or consultant physicians concurrently, each general practitioner, specialist or consultant physician may claim an attendance fee.
- (3) However, if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance.

### 2.8.2 Items in Group A5

This clause sets out items in Group A5.

Note: The fees in Group A5 are indexed in accordance with clause 1.3.1.

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<b>Group A5—Prolonged attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
160	Professional attendance for a period of not less than 1 hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	230.50
161	Professional attendance for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	384.15
162	Professional attendance for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	537.55
163	Professional attendance for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	691.50
164	Professional attendance for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	768.30

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## Division 2.9—Group A6: Group therapy

### 2.9.1 Items in Group A6

This clause sets out items in Group A6.

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Note: The fees in Group A6 are indexed in accordance with clause 1.3.1.

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**Group A6—Group therapy**


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<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
170	Professional attendance for the purpose of group therapy lasting at least 1 hour given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each group of 2 patients	122.35
171	Professional attendance for the purpose of group therapy lasting at least 1 hour given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each group of 3 patients	128.90
172	Professional attendance for the purpose of group therapy lasting at least 1 hour given under the direct continuous supervision of a general practitioner, specialist or consultant physician (other than a consultant physician in the practice of the consultant physician's specialty of psychiatry) involving members of a family and persons with close personal relationships with that family—each group of 4 or more patients	156.80

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## **Division 2.10—Group A7: Acupuncture and non-specialist practitioner items**

Note 1: Various restrictions, limitations and other requirements apply to items in Subgroups 5, 6, 7, 9 and 11 of Group A7. The restrictions, limitations and other requirements are set out in the following Divisions:

- (a) for items in Subgroup 5—Division 2.15;
- (b) for items in Subgroup 6—Division 2.16;
- (c) for items in Subgroup 7—Division 2.17;
- (d) for items in Subgroup 9—Division 2.20;
- (e) for items in Subgroup 11—Division 2.22.

Note 2: A number of expressions used in Subgroups 6, 7 and 9 of Group A7 are defined in Divisions 2.16, 2.17 and 2.20, including the following:

- (a) contribute to a multidisciplinary care plan (see clause 2.16.3);
  - (b) coordinating a review of team care arrangements (see clause 2.16.5);
  - (c) multidisciplinary care plan (see clause 2.16.6);
  - (d) organise and coordinate (see clause 2.16.15);
  - (e) participate (see clause 2.16.16);
  - (f) preparing a GP management plan (see clause 2.16.7);
  - (g) residential medication management review (see clause 2.17.2);
  - (h) review of a GP mental health treatment plan (see clause 2.20.4).
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**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.10** Group A7: Acupuncture and non-specialist practitioner items

Clause 2.10.1

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**2.10.1 Restriction on treatment time**

For the purposes of items 193 to 199, treatment time for a medical practitioner does not include the period:

- (a) commencing immediately after the practitioner has completed applying all acupuncture stimuli on or through a patient's skin; and
- (b) ending immediately before the practitioner begins to remove the acupuncture stimuli from the patient;

unless the practitioner personally attends the patient during that period for a consultation related to the condition for which the acupuncture was performed or another consultation.

**2.10.1A Application of items 214 to 220**

- (1) Items 214 to 220 apply only to a service provided in the course of a personal attendance by one or more prescribed medical practitioners on a single patient on a single occasion.
- (2) If the professional attendance is provided by one or more prescribed medical practitioners concurrently, each prescribed medical practitioner may claim an attendance fee.
- (3) However, if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance.

**2.10.2 Items in Group A7**

This clause sets out items in Group A7.

Note: The fees in Group A7 are indexed in accordance with clause 1.3.1.

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<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Acupuncture</b>		
193	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting less than 20 minutes and including any of the following that are clinically relevant: <ul style="list-style-type: none"><li>(a) taking a patient history;</li><li>(b) performing a clinical examination;</li><li>(c) arranging any necessary investigation;</li><li>(d) implementing a management plan;</li><li>(e) providing appropriate preventive health care;</li></ul> for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the	38.55

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<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	
195	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, on one or more patients at a hospital, for treatment lasting less than 20 minutes and including any of the following that are clinically relevant: <ul style="list-style-type: none"> <li>(a) taking a patient history;</li> <li>(b) performing a clinical examination;</li> <li>(c) arranging any necessary investigation;</li> <li>(d) implementing a management plan;</li> <li>(e) providing appropriate preventive health care;</li> </ul> for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	Amount under clause 2.1.1
197	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 20 minutes and including any of the following that are clinically relevant: <ul style="list-style-type: none"> <li>(a) taking a detailed patient history;</li> <li>(b) performing a clinical examination;</li> <li>(c) arranging any necessary investigation;</li> <li>(d) implementing a management plan;</li> <li>(e) providing appropriate preventive health care;</li> </ul> for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	74.60
199	Professional attendance by a medical practitioner who holds endorsement of registration for acupuncture with the Medical Board of Australia or is registered by the Chinese Medicine Board of Australia as an acupuncturist, at a place other than a hospital, for treatment lasting at least 40 minutes and including any of the following that are clinically relevant:	109.85

Schedule 1 General medical services table

Part 2 Attendances

Division 2.10 Group A7: Acupuncture and non-specialist practitioner items

Clause 2.10.2

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation, at which acupuncture is performed by the medical practitioner by the application of stimuli on or through the skin by any means, including any consultation on the same occasion and another attendance on the same day related to the condition for which the acupuncture is performed	
<b>Subgroup 2—Prescribed medical practitioner attendance to which no other item applies</b>		
179	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance	15.15
181	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting not more than 5 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
185	Professional attendance at consulting rooms lasting more than 5 minutes but not more than 25 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance	33.10
187	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 5 minutes but not more than 25 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
189	Professional attendance at consulting rooms lasting more than 25 minutes but not more than 45 minutes (other than a service to which any other applies) by a prescribed medical practitioner in an eligible area—each attendance	64.10
191	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 25 minutes but not more than 45 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
203	Professional attendance at consulting rooms lasting more than 45 minutes but not more than 60 minutes (other than a service to which any other item applies) by a prescribed medical practitioner in an eligible area—each attendance	94.40
206	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item	Amount under clause 2.1.2

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	applies) lasting more than 45 minutes but not more than 60 minutes— an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	
301	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which any other item in this Schedule applies) by a prescribed medical practitioner in an eligible area—each attendance	152.95
303	Professional attendance (other than an attendance at consulting rooms or a residential aged care facility or a service to which any other item applies) lasting more than 60 minutes—an attendance on one or more patients at one place on one occasion by a prescribed medical practitioner in an eligible area—each patient	Amount under clause 2.1.2
<b>Subgroup 3—Prescribed medical practitioner prolonged attendances to which no other item applies</b>		
214	Professional attendance by a prescribed medical practitioner for a period of not less than one hour but less than 2 hours (other than a service to which another item applies) on a patient in imminent danger of death	195.10
215	Professional attendance by a prescribed medical practitioner for a period of not less than 2 hours but less than 3 hours (other than a service to which another item applies) on a patient in imminent danger of death	325.10
218	Professional attendance by a prescribed medical practitioner for a period of not less than 3 hours but less than 4 hours (other than a service to which another item applies) on a patient in imminent danger of death	454.90
219	Professional attendance by a prescribed medical practitioner for a period of not less than 4 hours but less than 5 hours (other than a service to which another item applies) on a patient in imminent danger of death	585.20
220	Professional attendance by a prescribed medical practitioner for a period of 5 hours or more (other than a service to which another item applies) on a patient in imminent danger of death	650.20
<b>Subgroup 4—Prescribed medical practitioner group therapy</b>		
221	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 2 patients	103.50
222	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 3 patients	109.10

Schedule 1 General medical services table

Part 2 Attendances

Division 2.10 Group A7: Acupuncture and non-specialist practitioner items

Clause 2.10.2

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
223	Professional attendance for the purpose of Group therapy lasting at least one hour given under the direct continuous supervision of a prescribed medical practitioner, involving members of a family and persons with close personal relationships with that family—each Group of 4 or more patients	132.70
<b>Subgroup 5—Prescribed medical practitioner health assessments</b>		
224	Professional attendance by a prescribed medical practitioner to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	52.25
225	Professional attendance by a prescribed medical practitioner to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	121.45
226	Professional attendance by a prescribed medical practitioner to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	167.55
227	Professional attendance by a prescribed medical practitioner to perform a prolonged health assessment, lasting at least 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and (c) initiating interventions and referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient	236.70

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
228	Professional attendance by a prescribed medical practitioner at consulting rooms or in a place other than a hospital or a residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—applicable not more than once in a 9 month period and only if the following items are not applicable within the same 9 month period: (a) item 715; (b) item 92004 or 92011 of the Telehealth and Telephone Determination	186.90
<b>Subgroup 6—Prescribed medical practitioner management plans, team care arrangements and multidisciplinary care plans and case conferences</b>		
229	Attendance by a prescribed medical practitioner, for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply)	127.05
230	Attendance by a prescribed medical practitioner, to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply)	100.70
231	Either: (a) contribution to a multidisciplinary care plan, for a patient, prepared by another provider; or (b) contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply	62.00
232	Either: (a) contribution to a multidisciplinary care plan, for a patient in a residential aged care facility, prepared by that facility, or contribution to a review of a multidisciplinary care plan, for a patient, prepared by such a facility; or (b) contribution to a multidisciplinary care plan, for a patient, prepared by another provider before the patient is discharged from a hospital or contribution to a review of a multidisciplinary care plan, for a patient, prepared by another provider; by a prescribed medical practitioner, other than a service associated with a service to which any of items 235 to 240 and 735 to 758 apply	62.00
233	Attendance by a prescribed medical practitioner: (a) to review a GP management plan prepared by a medical practitioner (or an associated medical practitioner); or (b) to coordinate a review of team care arrangements which have been coordinated by the medical practitioner (or the associated medical practitioner)	63.45
235	Attendance by a prescribed medical practitioner, as a member of a	62.30

Schedule 1 General medical services table

Part 2 Attendances

Division 2.10 Group A7: Acupuncture and non-specialist practitioner items

Clause 2.10.2

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	
236	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	106.50
237	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts at least 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	177.50
238	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes but less than 20 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	45.75
239	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference;	78.40

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	if the conference lasts for at least 20 minutes but less than 40 minutes, other than a service associated with a service to any of items 229 to 233 and 721 to 732 apply	
240	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes, other than a service associated with a service to which any of items 229 to 233 and 721 to 732 apply	130.50
243	Attendance by a prescribed medical practitioner, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	61.00
244	Attendance by a prescribed medical practitioner, as a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer, to develop a multidisciplinary treatment plan, if the case conference lasts least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	28.45
969	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes	62.30
971	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes	106.50
972	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference if the conference lasts for at least 40 minutes	177.55
973	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 15 minutes, but for less than 20 minutes	45.75
975	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental	78.40

Schedule 1 General medical services table

Part 2 Attendances

Division 2.10 Group A7: Acupuncture and non-specialist practitioner items

Clause 2.10.2

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	health case conference if the conference lasts for at least 20 minutes, but for less than 40 minutes	
986	Attendance by a prescribed medical practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference if the conference lasts for at least 40 minutes	130.50
<b>Subgroup 7—Prescribed medical practitioner domiciliary and residential medication management review</b>		
245	<p>Participation by a prescribed medical practitioner in a Domiciliary Medication Management Review (<b>DMMR</b>) for a patient living in a community setting, in which the prescribed medical practitioner, with the patient’s consent:</p> <p>(a) assesses the patient as:</p> <p style="padding-left: 20px;">(i) having a chronic medical condition or a complex medication regimen; and</p> <p style="padding-left: 20px;">(ii) not having the patient’s therapeutic goals met; and</p> <p>(b) following that assessment:</p> <p style="padding-left: 20px;">(i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and</p> <p style="padding-left: 20px;">(ii) provides relevant clinical information required for the DMMR; and</p> <p>(c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and</p> <p>(d) develops a written medication management plan following discussion with the patient; and</p> <p>(e) provides the written medication management plan to a community pharmacy chosen by the patient</p> <p>For any particular patient—applicable not more than once in each 12 month period, and only if item 900 does not apply in the same 12 month period, except if there has been a significant change in the patient’s condition or medication regimen requiring a new DMMR</p>	136.35
249	Participation by a prescribed medical practitioner in a residential medication management review ( <b>RMMR</b> ) for a patient who is a permanent resident of a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 903 has applied, unless there has been a significant change in the resident’s medical condition or medication management plan requiring a new RMMR	93.35
<b>Subgroup 9—Prescribed medical practitioner mental health care</b>		
272	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	63.15
276	Professional attendance by a prescribed medical practitioner (who has not undertaken mental health skills training), lasting at least 40	92.95

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	minutes, for the preparation of a GP mental health treatment plan for a patient	
277	Professional attendance by a prescribed medical practitioner to: (a) review a GP mental health treatment plan which a medical practitioner, or an associated medical practitioner, has prepared; or (b) to review a Psychiatrist Assessment and Management Plan	63.15
279	Professional attendance by a prescribed medical practitioner, in relation to a mental disorder, lasting at least 20 minutes and involving: (a) taking relevant history and identifying the presenting problem (to the extent not previously recorded); and (b) providing treatment and advice; and (c) if appropriate, referral for other services or treatments; and (d) documenting the outcomes of the consultation	63.15
281	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 20 minutes but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	80.15
282	Professional attendance by a prescribed medical practitioner (who has undertaken mental health skills training), lasting at least 40 minutes, for the preparation of a GP mental health treatment plan for a patient	118.10
283	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes	81.70
285	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.20.2A
286	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes	116.90
287	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:	Amount under clause 2.20.2A

Schedule 1 General medical services table

Part 2 Attendances

Division 2.10 Group A7: Acupuncture and non-specialist practitioner items

Clause 2.10.2

<b>Group A7—Acupuncture and non-specialist practitioner items</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(a) for providing focussed psychological strategies for mental disorders that have been assessed by a medical practitioner; and (b) lasting at least 40 minutes	
309	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes	81.70
311	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.20.2A
313	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes	116.90
315	Professional attendance at a place other than consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies for assessed mental disorders to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 40 minutes	Amount under clause 2.20.2A
<b>Subgroup 11—Prescribed medical practitioner pregnancy support counselling</b>		
792	Professional attendance at consulting rooms by a prescribed medical practitioner, registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, lasting at least 20 minutes, for the purpose of providing non-directive pregnancy support counselling to a person who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item, or item 4001, 81000, 81005, 81010, 92136, 92137, 92138, 92139, 93026 or 93029, applies in relation to that pregnancy	67.45

**Group A7—Acupuncture and non-specialist practitioner items**

<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act. For items 92136, 92137, 92138, 92139, 93026 and 93029, see the Telehealth and Telephone Determination.	

**Division 2.11—Group A8: Consultant psychiatrist attendances to which no other item applies****2.11.2 Restriction on items 342, 344 and 346**

Items 342, 344 and 346 apply only to a service provided in the course of a personal attendance by a single medical practitioner.

**2.11.3 Certain services may be provided by video conference rather than at consulting rooms**

A service provided to a patient under item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 may be provided by video conference rather than at consulting rooms if the service is associated with a service to which item 294 applies.

**2.11.4 Meaning of risk assessment**

In item 289:

**risk assessment** means an assessment of:

- (a) the risk to the patient of a contributing co-morbidity; and
- (b) environmental, physical, social and emotional risk factors that may apply to the patient or to another individual.

**2.11.5 Items in Group A8**

This clause sets out items in Group A8.

Note: The fees in Group A8 are indexed in accordance with clause 1.3.1.

**Group A8—Consultant psychiatrist attendances to which no other item applies**

<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
289	Professional attendance lasting at least 45 minutes, by a consultant physician in the practice of the consultant physician's specialty of psychiatry, following referral of the patient to the consultant psychiatrist by a referring practitioner, for a patient aged under 25, if the consultant psychiatrist:	278.75

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.11** Group A8: Consultant psychiatrist attendances to which no other item applies

Clause 2.11.5

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>(a) undertakes, or has previously undertaken in prior attendances, a comprehensive assessment in relation to which a diagnosis of a complex neurodevelopmental disorder (such as autism spectrum disorder) is made (if appropriate, using information provided by an eligible allied health provider); and</p> <p>(b) develops a treatment and management plan, which must include:</p> <ul style="list-style-type: none"> <li>(i) documentation of the confirmed diagnosis; and</li> <li>(ii) findings of any assessments performed for the purposes of formulation of the diagnosis or contribution to the treatment and management plan; and</li> <li>(iii) a risk assessment; and</li> <li>(iv) treatment options (which may include biopsychosocial recommendations); and</li> </ul> <p>(c) provides a copy of the treatment and management plan to:</p> <ul style="list-style-type: none"> <li>(i) the referring practitioner; and</li> <li>(ii) one or more allied health providers, if appropriate, for the treatment of the patient;</li> </ul> <p>(other than attendance on a patient for whom payment has previously been made under this item or item 135, 137, 139, 92140, 92141, 92142 or 92434)</p> <p>Applicable only once per lifetime</p>	
291	<p>Professional attendance lasting more than 45 minutes at consulting rooms by a consultant physician in the practice of the consultant physician’s specialty of psychiatry, if:</p> <p>(a) the attendance follows referral of the patient to the consultant, by a medical practitioner in general practice (including a general practitioner, but not a specialist or consultant physician) or a participating nurse practitioner, for an assessment or management; and</p> <p>(b) during the attendance, the consultant:</p> <ul style="list-style-type: none"> <li>(i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and</li> <li>(ii) carries out a mental state examination; and</li> <li>(iii) undertakes a comprehensive diagnostic assessment; and</li> </ul> <p>(c) the consultant decides that it is clinically appropriate for the patient to be managed by the referring practitioner without ongoing management by the consultant; and</p> <p>(d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes:</p> <ul style="list-style-type: none"> <li>(i) the comprehensive diagnostic assessment of the patient; and</li> <li>(ii) a management plan for the patient for the next 12 months that comprehensively evaluates the patient’s biopsychosocial factors and makes recommendations to the referring practitioner to manage the patient’s ongoing care in a biopsychosocial model; and</li> </ul>	505.70

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<p>(e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to:</p> <p>(i) the patient; and</p> <p>(ii) the patient’s carer (if any), if the patient agrees; and</p> <p>(f) in the preceding 12 months, a service to which this item or item 92435 applies has not been provided to the patient</p>	
293	<p>Professional attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms by a consultant physician in the practice of the consultant physician’s specialty of psychiatry, if:</p> <p>(a) the patient is being managed by a medical practitioner or a participating nurse practitioner in accordance with a management plan prepared by the consultant in accordance with item 291 or item 92435; and</p> <p>(b) the attendance follows referral of the patient to the consultant, by the medical practitioner or participating nurse practitioner managing the patient, for review of the management plan and the associated comprehensive diagnostic assessment; and</p> <p>(c) during the attendance, the consultant:</p> <p>(i) if it is clinically appropriate to do so—uses an appropriate outcome tool; and</p> <p>(ii) carries out a mental state examination; and</p> <p>(iii) reviews the comprehensive diagnostic assessment and undertakes additional assessment as required; and</p> <p>(iv) reviews the management plan; and</p> <p>(d) within 2 weeks after the attendance, the consultant prepares and gives to the referring practitioner a written report, which includes:</p> <p>(i) the revised comprehensive diagnostic assessment of the patient; and</p> <p>(ii) a revised management plan including updated recommendations to the referring practitioner to manage the patient’s ongoing care in a biopsychosocial model; and</p> <p>(e) if clinically appropriate, the consultant explains the diagnostic assessment and management plan, and gives a copy, to:</p> <p>(i) the patient; and</p> <p>(ii) the patient’s carer (if any), if the patient agrees; and</p> <p>(f) in the preceding 12 months, a service to which item 291 or item 92435 applies has been provided to the patient; and</p> <p>(g) in the preceding 12 months, a service to which this item or item 92436 applies has not been provided to the patient</p>	316.15
294	<p>Professional attendance on a patient by a consultant physician practising in the consultant physician’s specialty of psychiatry if:</p> <p>(a) the attendance is by video conference; and</p> <p>(b) except for the requirement for the attendance to be at consulting rooms—item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318 or 319 would otherwise apply to the attendance;</p>	50% of the fee for the relevant item referred to in paragraph (b) of column 2

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.11** Group A8: Consultant psychiatrist attendances to which no other item applies

Clause 2.11.5

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	and (c) the patient is not an admitted patient; and (d) the patient is bulk-billed; and (e) the patient: (i) is located: (A) within a Modified Monash 2, 3, 4, 5, 6 or 7 area; and (B) at the time of the attendance—at least 15 km by road from the physician; or (ii) is a care recipient in a residential aged care facility; or (iii) is a patient of: (A) an Aboriginal medical service; or (B) an Aboriginal community controlled health service; for which a direction made under subsection 19(2) of the Act applies	
296	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at consulting rooms if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item or any of items 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months	274.95
297	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at hospital if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant physician in the preceding 24 months; other than attendance on a patient in relation to whom this item or any of items 296, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months (H)	274.95
299	Professional attendance lasting more than 45 minutes by a consultant physician in the practice of the consultant physician's speciality of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance at a place other than consulting rooms or a hospital if the patient: (a) is a new patient for this consultant physician; or (b) has not received a professional attendance from this consultant	328.75

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	physician in the preceding 24 months; other than attendance on a patient in relation to whom this item or any of items 296, 297, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 has applied in the preceding 24 months	
300	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	45.75
302	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	91.30
304	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	140.55
306	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	194.00
308	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies have not exceeded 50 attendances in a calendar year for the patient	225.10
310	Professional attendance by a consultant physician in the practice of	22.80

Schedule 1 General medical services table

Part 2 Attendances

Division 2.11 Group A8: Consultant psychiatrist attendances to which no other item applies

Clause 2.11.5

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	
312	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	45.75
314	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	70.45
316	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	97.10
318	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at consulting rooms, if that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839 and 92437 applies exceed 50 attendances in a calendar year for the patient	112.60
319	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes at consulting rooms, if: (a) the formulation of the patient's clinical presentation indicates intensive psychotherapy is a clinically appropriate and indicated treatment; and	205.20

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(b) that attendance and another attendance to which any of items 296, 297, 299, 300, 302, 304, 306, 308, 91827 to 91831, 91837 to 91839, 91873 and 92437 applies have not exceeded 160 attendances in a calendar year for the patient	
320	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes at hospital	45.75
322	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, at hospital	91.30
324	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, at hospital	140.55
326	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, at hospital	194.00
328	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes at hospital	225.10
330	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting not more than 15 minutes if that attendance is at a place other than consulting rooms or hospital	84.05
332	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 15 minutes, but not more than 30 minutes, if that attendance is at a place other than consulting rooms or hospital	131.60
334	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 30 minutes, but not more than 45 minutes, if that attendance is at a place other than consulting rooms or hospital	191.80
336	Professional attendance by a consultant physician in the practice of	232.05

**Schedule 1** General medical services table**Part 2** Attendances**Division 2.11** Group A8: Consultant psychiatrist attendances to which no other item applies

## Clause 2.11.5

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 45 minutes, but not more than 75 minutes, if that attendance is at a place other than consulting rooms or hospital	
338	Professional attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner—an attendance lasting more than 75 minutes if that attendance is at a place other than consulting rooms or hospital	263.55
341	An interview, lasting not more than 15 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 343, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	48.40
342	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) lasting at least 1 hour given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a group of 2 to 9 unrelated patients or a family group of more than 3 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	52.05
343	An interview, lasting more than 15 minutes but not more than 30 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 345, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	96.60
344	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) lasting at least 1 hour given under the continuous direct supervision of a consultant	69.10

<b>Group A8—Consultant psychiatrist attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 3 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	
345	An interview, lasting more than 30 minutes but not more than 45 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 347, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	148.70
346	Group psychotherapy (including any associated consultations with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) lasting at least 1 hour given under the continuous direct supervision of a consultant physician in the practice of the consultant physician's specialty of psychiatry, involving a family group of 2 patients, each of whom is referred to the consultant physician by a referring practitioner—each patient	102.20
347	An interview, lasting more than 45 minutes but not more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of items 341, 343, 345, 349, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	205.20
349	An interview, lasting more than 75 minutes, of a person other than the patient when the patient is not in attendance, by a consultant physician in the practice of the consultant physician's specialty of psychiatry following referral of the patient to the consultant physician by a referring practitioner, for the purposes of: (a) initial diagnostic evaluation; or (b) continuing management of the patient; if that service and another service to which this item or any of	238.15

Schedule 1 General medical services table

Part 2 Attendances

Division 2.12 Group A12: Consultant occupational physician attendances to which no other item applies

Clause 2.12.1

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**Group A8—Consultant psychiatrist attendances to which no other item applies**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	items 341, 343, 345, 347, 91874 to 91878 and 91882 to 91884 applies have not exceeded 15 services in a calendar year in relation to the patient	

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**Division 2.12—Group A12: Consultant occupational physician attendances to which no other item applies**

**2.12.1 Restrictions on items in Group A12—attendances by consultant occupational physicians**

Items 385 to 388 apply to an attendance by a consultant occupational physician only if the attendance relates to one or more of the following matters:

- (a) evaluating and assessing a patient’s rehabilitation requirements when, in the consultant’s opinion, the patient has an accepted medical condition that:
  - (i) may be affected by the patient’s working environment; or
  - (ii) affects the patient’s capacity to be employed;
- (b) managing an accepted medical condition that, in the consultant’s opinion, may affect a patient’s capacity for continued employment, or return to employment, following a non-compensable accident, injury or ill-health;
- (c) evaluating and forming an opinion about, including management as the case requires, a patient’s medical condition when causation may be related to acute or chronic exposure to scientifically acknowledged environmental hazards or toxins.

**2.12.2 Items in Group A12**

This clause sets out items in Group A12.

Note: The fees in Group A12 are indexed in accordance with clause 1.3.1.

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**Group A12—Consultant occupational physician attendances to which no other item applies**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
385	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician’s specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—initial attendance in a single course of treatment	90.35
386	Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician’s specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—an attendance after the initial attendance in a single course	45.40

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**Group A12—Consultant occupational physician attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	of treatment	
387	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—initial attendance in a single course of treatment	132.60
388	Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of the consultant occupational physician's specialty of occupational medicine following referral of the patient to the consultant occupational physician by a referring practitioner—an attendance after the initial attendance in a single course of treatment	83.95

**Division 2.13—Group A13: Public health physician attendances to which no other item applies****2.13.1 Restrictions on items in Group A13—attendances by public health physicians**

Items 410 to 417 apply to an attendance on a patient by a public health physician only if the attendance relates to one or more of the following matters:

- (a) management of a patient's vaccination requirements for immunisation programs;
- (b) prevention or management of sexually transmitted disease;
- (c) prevention or management of disease caused by scientifically accepted environmental hazards or toxins;
- (d) prevention or management of infection arising from an outbreak of an infectious disease;
- (e) prevention or management of an exotic disease.

**2.13.2 Items in Group A13**

This clause sets out items in Group A13.

Note: The fees in Group A13 are indexed in accordance with clause 1.3.1.

**Group A13—Public health physician attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
410	Professional attendance at consulting rooms by a public health physician in the practice of the public health physician's specialty of public health medicine—attendance for an obvious problem	20.65

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.13** Group A13: Public health physician attendances to which no other item applies

Clause 2.13.2

<b>Group A13—Public health physician attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	
411	Professional attendance by a public health physician in the practice of the public health physician’s specialty of public health medicine at consulting rooms, lasting less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	45.15
412	Professional attendance by a public health physician in the practice of the public health physician’s specialty of public health medicine at consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	87.35
413	Professional attendance by a public health physician in the practice of the public health physician’s specialty of public health medicine at consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	128.60
414	Professional attendance at other than consulting rooms by a public health physician in the practice of the public health physician’s specialty of public health medicine—attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	Amount under clause 2.1.1
415	Professional attendance by a public health physician in the practice of the public health physician’s specialty of public health medicine at other than consulting rooms, lasting less than 20 minutes and including	Amount under clause 2.1.1

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**Group A13—Public health physician attendances to which no other item applies**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
416	Professional attendance by a public health physician in the practice of the public health physician’s specialty of public health medicine at other than consulting rooms, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1
417	Professional attendance by a public health physician in the practice of the public health physician’s specialty of public health medicine at other than consulting rooms, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	Amount under clause 2.1.1

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## **Division 2.14—Group A11: Urgent attendances after—hours**

### **2.14.1 Meaning of patient’s medical condition requires urgent assessment**

- (1) A *patient’s medical condition requires urgent assessment* if:
  - (a) medical opinion is to the effect that the patient’s medical condition requires assessment within the unbroken after-hours period in which the attendance mentioned in the item was requested; and
  - (b) assessment could not be delayed until the start of the next in-hours period.
- (2) For the purposes of subclause (1), medical opinion is to a particular effect if:
  - (a) the attending practitioner is of that opinion; and

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.14** Group A11: Urgent attendances after—hours

Clause 2.14.2

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- (b) in the circumstances that existed and on the information available when the opinion was formed, that opinion would be acceptable to the general body of medical practitioners.

**2.14.2 Restrictions on items in Group A11**

- (1) Items 585 to 600 do not apply to a service provided by a medical practitioner if:
  - (a) the service is provided at consulting rooms; and
  - (b) the practitioner:
    - (i) routinely provides services to patients in after-hours periods at consulting rooms; or
    - (ii) provides the service (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms.
- (2) Items 585 to 600 do not apply to a professional attendance requested by:
  - (a) the attending medical practitioner; or
  - (b) an employee of the attending medical practitioner; or
  - (c) a person contracted by, or an employee or member of, the general practice of which the attending medical practitioner is a contractor, employee or member; or
  - (d) a call centre; or
  - (e) a reception service.
- (3) Also, item 585, 588, 591, 599 or 600 applies to a service only if the practitioner keeps a record of the assessment of the patient.

**2.14.4 Restrictions on items in Group A11—practitioners**

- (1) Item 585 does not apply to a service described in the item that is provided by an eligible non-vocationally recognised medical practitioner registered under the Other Medical Practitioners Extension Program (within the meaning of subclause 1.1.2(2)) who:
  - (a) was registered under the After Hours Other Medical Practitioners Program on or before 30 June 2023; and
  - (b) provides the service through a medical deputising service.
- (2) Each of items 588 and 591 apply to a service described in the item only if the service is provided by:
  - (a) a medical practitioner other than a general practitioner; or
  - (b) an eligible non-vocationally recognised medical practitioner registered under the Other Medical Practitioners Extension Program (within the meaning of subclause 1.1.2(2)) who:
    - (i) was registered under the After Hours Other Medical Practitioners Program on or before 30 June 2023; and
    - (ii) provides the service through a medical deputising service.

### 2.14.5 Items in Group A11

This clause sets out items in Group A11.

Note: The fees in Group A11 are indexed in accordance with clause 1.3.1.

<b>Group A11—Urgent attendances after hours</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
585	Professional attendance by a general practitioner on one patient on one occasion in an after-hours period outside unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient’s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	135.10
588	Professional attendance by a medical practitioner on one patient on one occasion in an after-hours period outside unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient’s medical condition requires urgent assessment; and (c) the attendance is in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	135.10
591	Professional attendance by a medical practitioner on one patient on one occasion in an after-hours period outside unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient’s medical condition requires urgent assessment; and (c) the attendance is not in an after-hours rural area; and (d) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	93.65
594	Professional attendance by a medical practitioner—each additional patient at an attendance that qualifies for item 585, 588 or 591 in relation to the first patient	43.65
599	Professional attendance by a general practitioner on one patient on one occasion in unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient’s medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	159.20

Schedule 1 General medical services table

Part 2 Attendances

Division 2.15 Group A14 and Subgroup 5 of Group A7: Health assessments

Clause 2.15.1

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**Group A11—Urgent attendances after hours**

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<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
600	Professional attendance by a medical practitioner (other than a general practitioner) on one patient on one occasion in unsociable hours if: (a) the attendance is requested by or on behalf of the patient in the same unbroken after-hours period; and (b) the patient's medical condition requires urgent assessment; and (c) if the attendance is at consulting rooms—it is necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance	127.25

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**Division 2.15—Group A14 and Subgroup 5 of Group A7: Health assessments**

Note: Items in Subgroup 5 of Group A7 are set out in Division 2.10.

**2.15.1 Restrictions on items in Group A14 and Subgroup 5 of Group A7**

- (1) Items 701 to 715 apply only to a service provided in the course of a personal attendance by a single general practitioner on a single patient.
- (2) Items 224 to 228 apply only to a service provided in the course of a personal attendance by a single prescribed medical practitioner on a single patient.

**2.15.2 Types of health assessments**

- (1) The following health assessments may be performed under item 701, 703, 705, 707, 224, 225, 226 or 227:
  - (a) a Type 2 Diabetes Risk Evaluation, in accordance with clause 2.15.4, for a patient who:
    - (i) is at least 40 years old and under 50 years old; and
    - (ii) has a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool; and
    - (iii) is not an in-patient of a hospital;
  - (b) a 45 year old Health Assessment, in accordance with clause 2.15.5, for a patient who is:
    - (i) at least 45 years old and under 50 years old; and
    - (ii) at risk of developing a chronic disease; and
    - (iii) not an in-patient of a hospital or a care recipient in a residential aged care facility;
  - (c) an Older Person's Health Assessment, in accordance with clause 2.15.6, for a patient who is:
    - (i) at least 75 years old; and

- (ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;
- (d) a Comprehensive Medical Assessment, in accordance with clause 2.15.7, for a patient who is a care recipient in a residential aged care facility;
- (e) a health assessment, in accordance with clause 2.15.8, for a person with an intellectual disability, if the patient is not an in-patient of a hospital or a care recipient in a residential aged care facility;
- (f) a health assessment, in accordance with clause 2.15.9, for a patient who:
  - (i) is a refugee or humanitarian entrant, with eligibility for Medicare; and
  - (ii) either:
    - (A) holds a relevant visa that the person has held for less than 12 months at the time of the assessment; or
    - (B) first entered Australia less than 12 months before the assessment is performed; and
  - (iii) is not an in-patient of a hospital or a care recipient in a residential aged care facility;
- (g) a health assessment, in accordance with clause 2.15.10, for a patient who:
  - (i) is a veteran, being a former member of the Permanent Forces (within the meaning of the *Defence Act 1903*) or a former member of the Reserves (within the meaning of that Act); and
  - (ii) has not already received such an assessment.

(2) In this clause:

**relevant visa** means any of the following visas granted under the *Migration Act 1958*:

- (a) Subclass 070 Bridging (Removal Pending) visa;
- (b) Subclass 200 (Refugee) visa;
- (c) Subclass 201 (In-country Special Humanitarian) visa;
- (d) Subclass 202 (Global Special Humanitarian) visa;
- (e) Subclass 203 (Emergency Rescue) visa;
- (f) Subclass 204 (Woman at Risk) visa;
- (h) Subclass 786 (Temporary (Humanitarian Concern)) visa;
- (ha) Subclass 790 (Safe Haven Enterprise) visa;
- (i) Subclass 866 (Protection) visa.

### **2.15.3 Application of items 715 and 228**

- (1) Items 715 and 228 apply to the following health assessments:
  - (a) an Aboriginal and Torres Strait Islander child health assessment, in accordance with clause 2.15.11, for a patient if the patient is:
    - (i) under 15 years old; and
    - (ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;
  - (b) an Aboriginal and Torres Strait Islander adult health assessment, in accordance with clause 2.15.12, for a patient if the patient is:

Clause 2.15.4

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- (i) at least 15 years old and under 55 years old; and
  - (ii) not an in-patient of a hospital or a care recipient in a residential aged care facility;
  - (c) an Aboriginal and Torres Strait Islander Older Person's Health Assessment, in accordance with clause 2.15.13, for a patient if the patient is:
    - (i) at least 55 years old; and
    - (ii) not an in-patient of a hospital or a care recipient in a residential aged care facility.
- (2) For the purpose of items 715 and 228, a person is of Aboriginal or Torres Strait Islander descent if the person identifies as being of that descent.

### 2.15.4 Type 2 Diabetes Risk Evaluation

- (1) A Type 2 Diabetes Risk Evaluation must include:
- (a) a review of the risk factors underlying a patient's high risk score as identified by the Australian Type 2 Diabetes Risk Assessment Tool; and
  - (b) initiating interventions, if appropriate, to address risk factors or to exclude diabetes.
- (2) The Type 2 Diabetes Risk Evaluation for a patient must also include:
- (a) assessing the patient's high risk score as determined by the Australian Type 2 Diabetes Risk Assessment Tool (to be completed by the patient within 3 months before performing the Type 2 Diabetes Risk Evaluation); and
  - (b) updating the patient's history and performing physical examinations and clinical investigations; and
  - (c) making an overall assessment of the patient's risk factors and the results of examinations and investigations; and
  - (d) initiating interventions, if appropriate, including referrals and follow-up services relating to the management of any risk factors identified; and
  - (e) giving the patient advice and information, including strategies to achieve lifestyle and behaviour changes if appropriate.
- (3) A Type 2 Diabetes Risk Evaluation must not be provided more than once every 3 years to an eligible person.
- (4) For this clause, **risk factors** includes:
- (a) lifestyle risk factors (for example smoking, physical inactivity or poor nutrition); and
  - (b) biomedical risk factors (for example high blood pressure, impaired glucose metabolism or excess weight); and
  - (c) a family history of a chronic disease.

### 2.15.5 45 year old Health Assessment

- (1) A 45 year old Health Assessment is an assessment for a patient if the patient, in the clinical judgement of the attending general practitioner, or attending
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prescribed medical practitioner, as the case may be, based on the identification of a specific risk factor, is at risk of developing a chronic disease.

- (2) The 45 year old Health Assessment must include:
  - (a) information collection, including taking a patient's history and performing examinations and investigations, as required; and
  - (b) making an overall assessment of the patient; and
  - (c) initiating interventions or referrals, as appropriate; and
  - (d) giving health advice and information to the patient.
- (3) The medical practitioner providing the assessment is responsible for the overall health assessment of the patient.
- (4) A 45 year old Health Assessment must not be given more than once to an eligible person.
- (5) In this clause:

***chronic disease*** means a disease that has been, or is likely to be, present for at least 6 months, including asthma, cancer, cardiovascular illness, diabetes mellitus, a mental health condition, arthritis or a musculoskeletal condition.

***specific risk factors*** includes:

- (a) lifestyle risk factors (for example smoking, physical inactivity, poor nutrition or alcohol misuse); and
- (b) biomedical risk factors (for example high cholesterol, high blood pressure, impaired glucose metabolism or excess weight); and
- (c) a family history of a chronic disease.

### **2.15.6 Older Person's Health Assessment**

- (1) An Older Person's Health Assessment is the assessment of:
  - (a) a patient's health and physical, psychological and social function; and
  - (b) whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological and social function.
- (2) An Older Person's Health Assessment must include:
  - (a) personal attendance by a general practitioner or a prescribed medical practitioner; and
  - (b) measurement of the patient's blood pressure, pulse rate and rhythm; and
  - (c) assessment of the patient's medication; and
  - (d) assessment of the patient's continence; and
  - (e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
  - (f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and

Clause 2.15.7

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- (g) assessment of the patient's psychological function, including the patient's cognition and mood; and
  - (h) assessment of the patient's social function, including:
    - (i) the availability and adequacy of paid, and unpaid, help; and
    - (ii) whether the patient is responsible for caring for another person.
- (3) An Older Person's Health Assessment must also include:
- (a) keeping a record of the health assessment; and
  - (b) offering the patient a written report on the health assessment, with recommendations about matters covered by the health assessment; and
  - (c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.
- (4) An Older Person's Health Assessment must not be provided more than once every 12 months to an eligible person.

**2.15.7 Comprehensive Medical Assessment for care recipient in a residential aged care facility**

- (1) A Comprehensive Medical Assessment of a care recipient in a residential aged care facility includes an assessment of the resident's health and physical and psychological function.
- (2) A Comprehensive Medical Assessment must include:
- (a) a personal attendance by a general practitioner or a prescribed medical practitioner; and
  - (b) taking a detailed patient history of the resident; and
  - (c) conducting a comprehensive medical examination of the resident; and
  - (d) developing a list of diagnoses and medical problems based on the medical history and examination; and
  - (e) giving a written copy of a summary of the outcomes of the assessment to the residential aged care facility for the resident's medical records.
- (3) A Comprehensive Medical Assessment must also include:
- (a) making a written summary of the Comprehensive Medical Assessment; and
  - (b) giving a copy of the summary to the residential aged care facility; and
  - (c) offering the resident a copy of the summary.
- (4) A Comprehensive Medical Assessment may be provided:
- (a) on admission to a residential aged care facility, if a Comprehensive Medical Assessment has not already been provided in another residential aged care facility in the last 12 months; and
  - (b) at 12 month intervals after that assessment.
- (5) A Comprehensive Medical Assessment may be performed in conjunction with a consultation for another purpose, but must be claimed separately.

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### **2.15.8 Health assessment for a person with an intellectual disability**

- (1) A health assessment for a person with an intellectual disability is an assessment of:
  - (a) the patient's physical, psychological and social function; and
  - (b) whether any medical intervention and preventive health care is required.
- (2) The health assessment for a person with an intellectual disability must include the following matters to the extent that they are relevant to the patient:
  - (a) checking dental health (including dentition);
  - (b) conducting an aural examination (including arranging a formal audiometry if an audiometry has not been conducted within the last 5 years);
  - (c) assessing ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within the last 5 years);
  - (d) assessing nutritional status (including weight and height measurements) and a review of growth and development;
  - (e) assessing bowel and bladder function (particularly for incontinence or chronic constipation);
  - (f) assessing medications including:
    - (i) non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications; and
    - (ii) advice to carers on the common side-effects and interactions; and
    - (iii) consideration of the need for a formal medication review;
  - (g) checking immunisation status (including influenza, tetanus, hepatitis A and B, measles, mumps, rubella and pneumococcal vaccinations);
  - (h) checking exercise opportunities (with the aim of moderate exercise for at least 30 minutes each day);
  - (i) checking whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and considering formal review if required;
  - (j) considering the need for breast examination, mammography, papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;
  - (k) checking for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy) and arranging for investigation or treatment as required;
  - (l) assessing risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication and fracture history) and arranging for investigation or treatment as required;
  - (m) for a patient diagnosed with epilepsy—reviewing seizure control (including anticonvulsant drugs) and considering referral to a neurologist at appropriate intervals;
  - (n) screening for thyroid disease at least every 2 years (or yearly for patients with Down syndrome);

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**Clause 2.15.9**

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- (o) for a patient without a definitive aetiological diagnosis—considering referral to a genetic clinic every 5 years;
  - (p) assessing or reviewing treatment for co-morbid mental health issues;
  - (q) considering timing of puberty and management of sexual development, sexual activity and reproductive health;
  - (r) considering whether there are any signs of physical, psychological or sexual abuse.
- (3) A health assessment for a person with an intellectual disability must also include:
- (a) keeping a record of the health assessment; and
  - (b) offering the patient a written report on the health assessment; and
  - (c) offering the patient’s carer (if any, and if the general practitioner or the prescribed medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report; and
  - (d) offering relevant disability professionals (if the general practitioner or the prescribed medical practitioner considers it appropriate and the patient or, if appropriate, the patient’s carer, agrees) a copy of the report or extracts of the report.
- (4) A health assessment for a person with an intellectual disability must not be provided more than once every 12 months to an eligible person.

**2.15.9 Health assessment for a refugee or other humanitarian entrant**

- (1) A health assessment for a refugee or other humanitarian entrant is the assessment of:
- (a) the patient’s health and physical, psychological and social function; and
  - (b) whether preventive health care and education should be offered to the patient to improve their health and physical, psychological or social function.
- (2) A health assessment for a refugee or other humanitarian entrant must include:
- (a) a personal attendance by a general practitioner or a prescribed medical practitioner; and
  - (b) taking the patient’s history; and
  - (c) examining the patient; and
  - (d) performing or arranging any required investigations; and
  - (e) assessing the patient, using the information gained in paragraphs (b), (c) and (d); and
  - (f) developing a management plan addressing the patient’s health care needs, health problems and relevant conditions; and
  - (g) making or arranging any necessary interventions and referrals.
- (3) A health assessment for a refugee or other humanitarian entrant must also include:
- (a) keeping a record of the health assessment; and

- (b) offering to provide the patient with a written report of the health assessment.
- (4) A health assessment for a refugee or other humanitarian entrant must not be provided to a patient more than once.

### **2.15.10 Health assessment for a veteran**

- (1) A health assessment for a veteran is an assessment of:
  - (a) the patient's physical and psychological health and social function; and
  - (b) whether health care, education or other assistance should be offered to the patient to improve the patient's physical or psychological health or social function.
- (2) The assessment must be performed by the patient's usual doctor.
- (3) The assessment must not be performed in conjunction with a separate consultation in relation to the patient unless the consultation is clinically necessary.
- (4) The assessment may be performed using the *Veteran Health Check* tool, as existing on 2 September 2021.

Note 1: The *Veteran Health Check* tool could in 2021 be viewed on the Department of Veterans' Affairs' website (<http://dva.gov.au>).

Note 2: Other assessment tools mentioned in the Department of Veterans' Affairs' *Mental Health Advice Book* may be relevant. The *Mental Health Advice Book* could in 2021 be viewed on the Department of Veterans' Affairs' website (<http://dva.gov.au>).

- (5) The assessment must include taking a history of the patient that includes the following:
  - (a) the patient's service with the Australian Defence Force, including service type, years of service, field of work, number of deployments and reason for discharge;
  - (b) the patient's social history, including relationship status, number of children (if any) and current occupation;
  - (c) the patient's current medical conditions;
  - (d) whether the patient suffers from hearing loss or tinnitus;
  - (e) the patient's use of medication, including medication prescribed by another doctor and medication obtained without a prescription;
  - (f) the patient's smoking, if applicable;
  - (g) the patient's alcohol use, if applicable;
  - (h) the patient's substance use, if applicable;
  - (i) the patient's level of physical activity;
  - (j) whether the patient has bodily pain;
  - (k) whether the patient has difficulty getting to sleep or staying asleep;
  - (l) whether the patient has psychological distress;
  - (m) whether the patient has posttraumatic stress disorder;
  - (n) whether the patient is at risk of harm to self or others;

Clause 2.15.11

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- (o) whether the patient has anger problems;
  - (p) the patient's sexual health;
  - (q) any other health concerns the patient has.
- (6) The assessment must also include the following:
- (a) measuring the patient's height;
  - (b) weighing the patient and ascertaining, or asking the patient, whether the patient's weight has changed in the last 12 months;
  - (c) measuring the patient's waist circumference;
  - (d) taking the patient's blood pressure;
  - (e) using information gained in the course of taking the patient's history to assess whether any further assessment of the patient's health is necessary;
  - (f) either:
    - (i) making the further assessment mentioned in paragraph (e); or
    - (ii) referring the patient to another medical practitioner who can make the further assessment;
  - (g) documenting a strategy for improving the patient's health;
  - (h) offering to give the patient a written report of the assessment that makes recommendations for treating the patient including preventive health measures.
- (7) The doctor must keep a record of the assessment.
- (8) In this clause:
- usual doctor**, in relation to a patient, means a general practitioner, or a prescribed medical practitioner, employed by a medical practice:
- (a) that has provided at least 50% of the primary health care required by the patient in the last 12 months; or
  - (b) that the patient anticipates will provide at least 50% of the patient's primary health care requirements in the next 12 months.

**2.15.11 Aboriginal and Torres Strait Islander child health assessment**

- (1) An Aboriginal and Torres Strait Islander child health assessment is the assessment of:
- (a) a patient's health and physical, psychological and social function; and
  - (b) whether preventive health care, education and other assistance should be offered to the patient, or the patient's parent or carer, to improve the patient's health and physical, psychological or social function.
- (2) An Aboriginal and Torres Strait Islander child health assessment must include:
- (a) a personal attendance by a general practitioner or a prescribed medical practitioner; and
  - (b) taking the patient's history, including the following:
    - (i) mother's pregnancy history;
    - (ii) birth and neo-natal history;

- (iii) breastfeeding history;
  - (iv) weaning, food access and dietary history;
  - (v) physical activity engaged in;
  - (vi) previous presentations, hospital admissions and medication use;
  - (vii) relevant family medical history;
  - (viii) immunisation status;
  - (ix) vision and hearing (including neo-natal hearing screening);
  - (x) development (including achievement of age-appropriate milestones);
  - (xi) family relationships, social circumstances and whether the patient is cared for by another person;
  - (xii) exposure to environmental factors (including tobacco smoke);
  - (xiii) environmental and living conditions;
  - (xiv) educational progress;
  - (xv) stressful life events experienced;
  - (xvi) mood (including incidence of depression and risk of self-harm);
  - (xvii) substance use;
  - (xviii) sexual and reproductive health;
  - (xix) dental hygiene (including access to dental services); and
  - (c) examination of the patient, including the following:
    - (i) measurement of the patient's height and weight to calculate the patient's body mass index and position on the growth curve;
    - (ii) newborn baby check (if not previously completed);
    - (iii) vision (including red reflex in a newborn);
    - (iv) ear examination (including otoscopy);
    - (v) oral examination (including gums and dentition);
    - (vi) trachoma check, if indicated;
    - (vii) skin examination, if indicated;
    - (viii) respiratory examination, if indicated;
    - (ix) cardiac auscultation, if indicated;
    - (x) development assessment, to determine whether age-appropriate milestones have been achieved, if indicated;
    - (xi) assessment of parent and child interaction, if indicated;
    - (xii) other examinations as indicated by a previous child health assessment;and
  - (d) performing or arranging any required investigation, in particular considering the need for the following tests:
    - (i) haemoglobin testing for those at a high risk of anaemia;
    - (ii) audiometry, especially for school age children; and
  - (e) assessing the patient using the information gained in the child health assessment; and
  - (f) making or arranging any necessary interventions and referrals, and documenting a strategy for the good health of the patient; and
  - (g) both:
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Clause 2.15.12

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- (i) keeping a record of the health assessment; and
- (ii) offering the patient, or the patient's parent or carer, a written report on the health assessment, with recommendations on matters covered by the health assessment (including a strategy for the good health of the patient).

**2.15.12 Aboriginal and Torres Strait Islander adult health assessment**

- (1) An Aboriginal and Torres Strait Islander adult health assessment is the assessment of:
  - (a) a patient's health and physical, psychological and social function; and
  - (b) whether preventive health care, education and other assistance should be offered to the patient to improve their health and physical, psychological or social function.
- (2) An Aboriginal and Torres Strait Islander adult health assessment must include:
  - (a) personal attendance by a general practitioner or a prescribed medical practitioner; and
  - (b) taking the patient's history, including the following:
    - (i) current health problems and risk factors;
    - (ii) relevant family medical history;
    - (iii) medication use (including medication obtained without prescription or from other doctors);
    - (iv) immunisation status, by reference to the appropriate current age and sex immunisation schedule;
    - (v) sexual and reproductive health;
    - (vi) physical activity, nutrition and alcohol, tobacco or other substance use;
    - (vii) hearing loss;
    - (viii) mood (including incidence of depression and risk of self-harm);
    - (ix) family relationships and whether the patient is a carer, or is cared for by another person;
    - (x) vision; and
  - (c) examination of the patient, including the following:
    - (i) measurement of the patient's blood pressure, pulse rate and rhythm;
    - (ii) measurement of height and weight to calculate the patient's body mass index and, if indicated, measurement of waist circumference for central obesity;
    - (iii) oral examination (including gums and dentition);
    - (iv) ear and hearing examination (including otoscopy and, if indicated, a whisper test);
    - (v) urinalysis (by dipstick) for proteinuria;
    - (vi) eye examination; and
  - (d) performing or arranging any required investigation, in particular considering the need for the following tests:

- (i) fasting blood sugar and lipids (by laboratory-based test on venous sample) or, if necessary, random blood glucose levels;
  - (ii) papanicolaou smear;
  - (iii) examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those 15 to 35 years old);
  - (iv) mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral); and
  - (e) assessing the patient using the information gained in the health assessment; and
  - (f) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.
- (3) An Aboriginal and Torres Strait Islander adult health assessment must also include:
- (a) keeping a record of the health assessment; and
  - (b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment (including a simple strategy for the good health of the patient).

### **2.15.13 Aboriginal and Torres Strait Islander Older Person's Health Assessment**

- (1) An Aboriginal and Torres Strait Islander Older Person's Health Assessment is the assessment of:
- (a) a patient's health and physical, psychological and social function; and
  - (b) whether preventive health care and education should be offered to the patient, to improve the patient's health and physical, psychological or social function.
- (2) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must include:
- (a) personal attendance by a general practitioner or a prescribed medical practitioner; and
  - (b) measurement of the patient's blood pressure, pulse rate and rhythm; and
  - (c) assessment of the patient's medication; and
  - (d) assessment of the patient's continence; and
  - (e) assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
  - (f) assessment of the patient's physical functions, including the patient's activities of daily living and whether or not the patient has had a fall in the last 3 months; and
  - (g) assessment of the patient's psychological function, including the patient's cognition and mood; and
  - (h) assessment of the patient's social function, including:
    - (i) the availability and adequacy of paid, and unpaid, help; and
    - (ii) whether the patient is responsible for caring for another person; and

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Clause 2.15.14

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- (i) an examination of the patient's eyes.
- (3) An Aboriginal and Torres Strait Islander Older Person's Health Assessment must also include:
  - (a) keeping a record of the health assessment; and
  - (b) offering the patient a written report on the health assessment, with recommendations on matters covered by the health assessment; and
  - (c) offering the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

**2.15.14 Restrictions on health assessments for Group A14 and Subgroup 5 of Group A7**

- (1) A health assessment mentioned in an item in Group A14 or Subgroup 5 of Group A7 must not include a health screening service.
- (2) A separate consultation must not be performed in conjunction with a health assessment, unless clinically necessary.
- (3) A health assessment must be performed by the patient's usual general practitioner or prescribed medical practitioner, if reasonably practicable.
- (4) Practice nurses, Aboriginal health workers and Aboriginal and Torres Strait Islander health practitioners may assist general practitioners or prescribed medical practitioners in performing a health assessment, in accordance with accepted medical practice, and under the supervision of the general practitioner or the prescribed medical practitioner, as the case may be.
- (5) For the purposes of subclause (4), assistance may include activities associated with:
  - (a) information collection; and
  - (b) at the direction of the general practitioner or prescribed medical practitioner—provision to patients of information on recommended interventions.
- (6) In this clause:

*health screening service* has the same meaning as in subsection 19(5) of the Act.

**2.15.15 Items in Group A14**

This clause sets out items in Group A14.

Note: The fees in Group A14 are indexed in accordance with clause 1.3.1.

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**Group A14—Health assessments**

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<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
701	Professional attendance by a general practitioner (other than a specialist	61.75

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<b>Group A14—Health assessments</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	or consultant physician) to perform a brief health assessment, lasting not more than 30 minutes and including: (a) collection of relevant information, including taking a patient history; and (b) a basic physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing the patient with preventive health care advice and information	
703	Professional attendance by a general practitioner (other than a specialist or consultant physician) to perform a standard health assessment, lasting more than 30 minutes but less than 45 minutes, including: (a) detailed information collection, including taking a patient history; and (b) an extensive physical examination; and (c) initiating interventions and referrals as indicated; and (d) providing a preventive health care strategy for the patient	143.50
705	Professional attendance by a general practitioner (other than a specialist or consultant physician) to perform a long health assessment, lasting at least 45 minutes but less than 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient’s medical condition and physical function; and (c) initiating interventions and referrals as indicated; and (d) providing a basic preventive health care management plan for the patient	198.00
707	Professional attendance by a general practitioner (other than a specialist or consultant physician) to perform a prolonged health assessment, lasting at least 60 minutes, including: (a) comprehensive information collection, including taking a patient history; and (b) an extensive examination of the patient’s medical condition, and physical, psychological and social function; and (c) initiating interventions or referrals as indicated; and (d) providing a comprehensive preventive health care management plan for the patient	279.70
715	Professional attendance by a general practitioner (other than a specialist or consultant physician) at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent—not more than once in a 9 month period	220.85

## **Division 2.16—Group A15 and Subgroup 6 of Group A7: GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

Note: Items in Subgroup 6 of Group A7 are set out in Division 2.10.

### **Subdivision A—General**

#### **2.16.1 Restrictions on items 729 to 866 and items 229 to 240—services by certain medical practitioners**

- (1) Items 729 to 866 and items 229 to 240 apply only to a service provided by:
  - (a) a medical practitioner (other than a medical practitioner employed by the proprietor of a hospital that is not a private hospital); or
  - (b) a medical practitioner who:
    - (i) is employed by the proprietor of a hospital that is not a private hospital; and
    - (ii) provides the service otherwise than in the course of employment by that proprietor.
- (2) Paragraph (1)(b) applies whether or not another person provides essential assistance to the medical practitioner in accordance with accepted medical practice.

### **Subdivision B—Subgroup 1 of Group A15 and Subgroup 6 of Group A7**

#### **2.16.2 Meaning of associated general practitioner**

- (1) In item 732:

*associated general practitioner* means a general practitioner who, if not engaged in the same general practice as the general practitioner mentioned in the item, performs the service described in the item at the request of the patient (or the patient's guardian).

- (2) In item 233:

*associated medical practitioner* means a medical practitioner who, if not engaged in the same general practice as the prescribed medical practitioner mentioned in the item, performs the service described in the item at the request of the patient (or the patient's guardian).

#### **2.16.3 Meaning of contribute to a multidisciplinary care plan**

In items 729, 731, 231 and 232:

*contribute to a multidisciplinary care plan*, for a patient, includes the following:

- (a) preparing part of a multidisciplinary care plan and adding a copy of that part of the plan to the patient's medical records;

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- (b) preparing amendments to part of a multidisciplinary care plan and adding a copy of the amendments to the patient's medical records;
  - (c) giving advice to a person who prepares part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person;
  - (d) giving advice to a person who reviews part of a multidisciplinary care plan and recording in writing, on the patient's medical records, any advice provided to the person.

### 2.16.4 Meaning of coordinating the development of team care arrangements

- (1) In items 723 and 230:

*coordinating the development of team care arrangements* means a process by which a general practitioner (for item 723) or a prescribed medical practitioner (for item 230):

- (a) in consultation with at least 2 collaborating providers, each of whom provides a different kind of treatment or service, and one of whom may be another medical practitioner, makes arrangements for the multidisciplinary care of the patient; and
- (b) prepares a document that describes the following:
  - (i) treatment and service goals for the patient;
  - (ii) treatment and services that collaborating providers will provide to the patient;
  - (iii) actions to be taken by the patient;
  - (iv) arrangements to review the matters mentioned in subparagraphs (i), (ii) and (iii) by a day mentioned in the document; and
- (c) undertakes all of the following activities:
  - (i) explains the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
  - (ii) discusses with the patient the collaborating providers who will contribute to the development of team care arrangements, and provide treatment and services to the patient under those arrangements;
  - (iii) records the patient's agreement to the development of team care arrangements;
  - (iv) gives the collaborating provider a copy of those parts of the document that relate to the collaborating provider's treatment of the patient's condition;
  - (v) offers a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
  - (vi) adds a copy of the document to the patient's medical records.

- (2) For this clause, a *collaborating provider* is a person who:

- (a) provides treatment or a service to a patient; and

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Clause 2.16.5

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- (b) is not an unpaid carer of the patient.

**2.16.5 Meaning of coordinating a review of team care arrangements**

- (1) In items 732 and 233:

*coordinating a review of team care arrangements* means a process by which a general practitioner (for item 732) or a prescribed medical practitioner (for item 233):

- (a) in consultation with at least 2 collaborating providers, each of whom provides a different kind of treatment or service, and one of whom may be another medical practitioner, reviews the matters mentioned in:
  - (i) paragraph (b) of the definition of *coordinating the development of team care arrangements* in subclause 2.16.4(1); and
  - (ii) paragraph (a) of the definition of *preparing a GP management plan* in clause 2.16.7;as applicable; and
- (b) if different arrangements need to be made—makes amendments to the plan, or to the document mentioned in paragraph (b) of the definition of *coordinating the development of team care arrangements* in subclause 2.16.4(1), that:
  - (i) state the new arrangements; and
  - (ii) provide for the review of the amended plan or document by a date stated in the plan or document; and
- (c) explains the steps involved in the review to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- (d) records the patient’s agreement to the review of team care arrangements or the plan; and
- (e) gives the collaborating provider a copy of those parts of the amended document, or the amended plan, that relate to the collaborating provider’s treatment of the patient’s condition; and
- (f) offers a copy of the amended document, or plan, to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- (g) adds a copy of the amended document or plan to the patient’s medical records.

- (2) For this clause, a *collaborating provider* is a person who:

- (a) provides treatment or a service to a patient; and
- (b) is not an unpaid carer of the patient.

**2.16.6 Meaning of multidisciplinary care plan**

- (1) In items 729, 731, 231 and 232:

*multidisciplinary care plan*, for a patient, means a written plan that:

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- (a) is prepared for the patient by:
- (i) a general practitioner (for items 729 and 731) or a prescribed medical practitioner (for items 231 and 232), in consultation with 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient, and one of whom may be another medical practitioner; or
  - (ii) a collaborating provider (other than a general practitioner or a prescribed medical practitioner, as the case may be), in consultation with at least 2 other collaborating providers, each of whom provides a different kind of treatment or service to the patient; and
- (b) describes, at least, treatment and services to be provided to the patient by the collaborating providers.
- (2) For this clause, a **collaborating provider** is a person, including a medical practitioner, who:
- (a) provides treatment or a service to a patient; and
  - (b) is not an unpaid carer of the patient.

### 2.16.7 Meaning of preparing a GP management plan

In items 721 and 229:

**preparing a GP management plan**, for a patient, means a process by which a general practitioner (for item 721) or a prescribed medical practitioner (for item 229):

- (a) prepares a written plan for the patient that describes:
  - (i) the patient's condition and associated health care needs; and
  - (ii) management goals with which the patient agrees; and
  - (iii) actions to be taken by the patient; and
  - (iv) treatment and services the patient is likely to need; and
  - (v) arrangements for providing the treatment and services mentioned in subparagraph (a)(iv); and
  - (vi) arrangements to review the plan by a day mentioned in the plan; and
- (b) explains to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and
- (c) records the plan; and
- (d) records the patient's agreement to the preparation of the plan; and
- (e) offers a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- (f) adds a copy of the plan to the patient's medical records.

### 2.16.8 Meaning of reviewing a GP management plan

In items 732 and 233:

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**Clause 2.16.9**

**reviewing a GP management plan** means a process by which a general practitioner (for item 732) or a prescribed medical practitioner (for item 233):

- (a) reviews the matters mentioned in paragraph (a) of the definition of **preparing a GP management plan** in clause 2.16.7; and
- (b) if different arrangements need to be made—makes amendments to the plan that:
  - (i) state the new arrangements; and
  - (ii) provide for a further review of the amended plan by a date stated in the plan; and
- (c) explains to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review; and
- (d) records the patient’s agreement to the review of the plan; and
- (e) if amendments are made to the plan:
  - (i) offers a copy of the amended plan to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
  - (ii) adds a copy of the amended plan to the patient’s medical records.

**2.16.9 Restrictions on items 721, 723, 729, 731, 732, 229, 230, 231, 232 and 233—services for certain patients**

- (1) An item of this Schedule mentioned in column 1 of table 2.16.9 applies only to a service for a patient who:
  - (a) suffers from at least one medical condition that:
    - (i) has been (or is likely to be) present for at least 6 months; or
    - (ii) is terminal; and
  - (b) is described in column 2 of table 2.16.9.

**Table 2.16.9—Application of items 721, 723, 729, 731, 732, 229, 230, 231, 232 and 233**

<b>Item</b>	<b>Column 1 Items of this Schedule</b>	<b>Column 2 Description of patient</b>
1	721, 732, 229 and 233 (if the service is for preparing a GP management plan or reviewing a GP management plan)	The patient: <ul style="list-style-type: none"><li>(a) is a private in-patient of a hospital; or</li><li>(b) is not a public in-patient of a hospital or a care recipient in a residential aged care facility</li></ul>
2	723, 732, 230 and 233 (if the service is for the creation or review of team care arrangements)	The patient: <ul style="list-style-type: none"><li>(a) requires ongoing care from at least 3 collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and</li><li>(b) either:<ul style="list-style-type: none"><li>(i) is a private in-patient of a hospital; or</li></ul></li></ul>

**Table 2.16.9—Application of items 721, 723, 729, 731, 732, 229, 230, 231, 232 and 233**

<b>Item</b>	<b>Column 1 Items of this Schedule</b>	<b>Column 2 Description of patient</b>
		(ii) is not a public in-patient of a hospital or a care recipient in a residential aged care facility
3	729 and 231	The patient: (a) requires ongoing care from at least 3 collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (b) is not a care recipient in a residential aged care facility
4	731 and 232	The patient: (a) requires ongoing care from at least 3 collaborating providers, each of whom provides a different kind of treatment or service to the patient, and at least one of whom is a medical practitioner; and (b) is a care recipient in a residential aged care facility

(1A) Despite subclause (1), items 723, 732, 230 and 233 also apply to a service for a patient if:

- (a) the service is provided for the purpose of coordinating the development of team care arrangements, or coordinating a review of team care arrangements, for the patient; and
- (b) the patient:
  - (i) is referred for a service to which any of the following items apply:
    - (A) an item in Subgroup 2 of Group A20;
    - (B) an item in Subgroup 9 of Group A7;
    - (C) an item in Subgroup 3 or 10 of Group A40;
    - (D) an item in Group M6 or M7;
    - (E) an item in Subgroup 1, 2, 3, 4, 6, 7, 8 or 9 of Group M18; or
  - (ii) has an eating disorder treatment and management plan; and
- (c) the patient is described in column 2 of an item in table 2.16.9.

(2) For this clause, a **collaborating provider** is a person who:

- (a) provides treatment or a service to a patient; and
- (b) is not an unpaid carer of the patient.

### **2.16.10 Restrictions on items 721, 723, 732, 229, 230 and 233**

#### *Items 721, 723 and 732*

- (1) Items 721, 723 and 732 apply only to a service provided in the course of personal attendance by a single general practitioner on a single patient.

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Clause 2.16.11

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*Items 229, 230 and 233*

- (2) Items 229, 230 and 233 apply only to a service provided in the course of personal attendance by a single prescribed medical practitioner on a single patient.

**2.16.11 Restrictions on other items—services provided on same day as services in items 721, 723, 732, 229, 230 and 233**

The following items do not apply to a service described in the item that is provided by a medical practitioner or a prescribed medical practitioner, if the service is provided on the same day for the same patient for whom the practitioner provides a service described in item 721, 723, 732, 229, 230 or 233:

- (a) items 3, 4, 23, 24, 36, 37, 44, 47, 52, 53, 54, 57, 58, 59, 60, 65, 123, 124, 151 and 165;
- (b) items 179, 181, 185, 187, 189, 191, 203, 206, 301, 303, 733, 737, 741, 745, 761, 763, 766, 769, 2197 and 2198;
- (c) items 585, 588, 591, 594, 599 and 600;
- (d) items 5000, 5003, 5020, 5023, 5040, 5043, 5060, 5063, 5071 and 5076;
- (e) items 5200, 5203, 5207, 5208, 5209, 5220, 5223, 5227, 5228 and 5261;
- (f) items 91790, 91792, 91794, 91800, 91801, 91802, 91803, 91804, 91805, 91806, 91807, 91808, 91890, 91891, 91892, 91893, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923, 91926, 92210 and 92211.

**2.16.12 Conditions relating to timing of services in items 721, 723, 729, 731 and 732 if exceptional circumstances do not exist**

- (1) This clause applies to the performances of services for a patient for whom exceptional circumstances do not exist.
- (2) Items 721, 723, 729, 731 and 732 apply in the circumstances mentioned in table 2.16.12.

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**Table 2.16.12—Conditions relating to timing of services in items 721, 723, 729, 731 and 732**

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<b>Item</b>	<b>Column 1 Item of this Schedule</b>	<b>Column 2 Circumstances</b>
1	721	(a) In the 3 months before performance of the service, being a service to which item 729, 731 or 732 (for reviewing a GP management plan) applies but had not been performed for the patient; and (b) the service is not performed more than once in a 12 month period; and (c) the service is not performed by a general practitioner: (i) who is a recognised specialist in palliative medicine; and (ii) who is treating a palliative patient that has been referred to the general practitioner; and (iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the

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**Table 2.16.12—Conditions relating to timing of services in items 721, 723, 729, 731 and 732**

<b>Item</b>	<b>Column 1 Item of this Schedule</b>	<b>Column 2 Circumstances</b>
		general practitioner
2	723 (if subclause 2.16.9(1) applies to the item)	<p>(a) In the 3 months before performance of the service, being a service to which item 732 (for coordinating a review of team care arrangements, a multi-disciplinary community care plan or a multi-disciplinary discharge care plan in accordance with subclause 2.16.9(1)) applies but had not been performed for the patient; and</p> <p>(b) the service is performed not more than once in a 12 month period; and</p> <p>(c) the service is not performed by a general practitioner:</p> <ul style="list-style-type: none"> <li>(i) who is a recognised specialist in palliative medicine; and</li> <li>(ii) who is treating a palliative patient that has been referred to the general practitioner; and</li> <li>(iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner</li> </ul>
2A	723 (if subclause 2.16.9(1A) applies to the item)	<p>(a) In the 3 months before performance of the service, being a service to which item 732 (for coordinating the review of team care arrangements in accordance with subclause 2.16.9(1A)) applies but had not been performed for the patient; and</p> <p>(b) the service is performed not more than once in a 12 month period; and</p> <p>(c) the service is not performed by a general practitioner:</p> <ul style="list-style-type: none"> <li>(i) who is a recognised specialist in palliative medicine; and</li> <li>(ii) who is treating a palliative patient that has been referred to the general practitioner; and</li> <li>(iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner</li> </ul>
3	729	<p>(a) either:</p> <ul style="list-style-type: none"> <li>(i) in the 3 months before performance of the service, being a service to which item 731 or 732 applies but had not been performed for the patient; or</li> <li>(ii) in the 12 months before performance of the service, being a service that has not been performed for the patient: <ul style="list-style-type: none"> <li>(A) by the general practitioner who performs the service to which item 729 would, but for this item, apply; and</li> <li>(B) for which a payment has been made under item 721 or 723; and</li> </ul> </li> </ul> <p>(b) the service is performed not more than once in a 3 month period</p>
4	731	<p>(a) In the 3 months before performance of the service, being a service to which item 721, 723, 729 or 732 applies but had not been performed for the patient; and</p> <p>(b) the service is performed not more than once in a 3 month period</p>

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Clause 2.16.12A

**Table 2.16.12—Conditions relating to timing of services in items 721, 723, 729, 731 and 732**

<b>Item</b>	<b>Column 1 Item of this Schedule</b>	<b>Column 2 Circumstances</b>
5	732 (if subclause 2.16.9(1) applies to the item)	Each service: (a) may be performed: (i) once in a 3 month period; and (ii) on the same day; but (b) may not be performed by a general practitioner: (i) who is a recognised specialist in palliative medicine; and (ii) who is treating a palliative patient that has been referred to the general practitioner; and (iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner
5A	732 (if subclause 2.16.9(1A) applies to the item)	The service, being a service to which item 732 (for coordinating the review of team care arrangements) applies: (a) may be performed once in a 3 month period; but (b) may not be performed by a general practitioner: (i) who is a recognised specialist in palliative medicine; and (ii) who is treating a palliative patient that has been referred to the general practitioner; and (iii) to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the general practitioner

(3) In this clause:

*exceptional circumstances*, for a patient, means there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service for the patient.

**2.16.12A Conditions relating to timing of services in items 229, 230, 231, 232 and 233 if exceptional circumstances do not exist**

- (1) This clause applies to the performances of services for a patient for whom exceptional circumstances do not exist.
- (2) Items 229, 230, 231, 232 and 233 apply in the circumstances mentioned in table 2.16.12A.

**Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233**

Item	Column 1 Item of this Schedule	Column 2 Circumstances
1	229	<p>The circumstances are that:</p> <ul style="list-style-type: none"> <li>(a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items (for reviewing a GP management plan) apply but had not been performed for the patient: <ul style="list-style-type: none"> <li>(i) item 231, 232, 233, 729, 731 or 732;</li> <li>(ii) item 92026, 92027, 92028, 92057, 92058, 92059 or 92103 of the Telehealth and Telephone Determination; and</li> </ul> </li> <li>(b) a service to which item 721, or item 92024, 92026 or 92055 of the Telehealth and Telephone Determination, applies has not been performed in the past 12 months; and</li> <li>(c) the service to which item 229 applies is not performed more than once in a 12 month period; and</li> <li>(d) the service to which item 229 applies: <ul style="list-style-type: none"> <li>(i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and</li> <li>(ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the medical practitioner</li> </ul> </li> </ul>
2	230 (if subclause 2.16.9(1) applies to the item)	<p>The circumstances are that:</p> <ul style="list-style-type: none"> <li>(a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items (for coordinating a review of team care arrangements) apply but had not been performed for the patient: <ul style="list-style-type: none"> <li>(i) item 233 or 723 (performed in accordance with subclause 2.16.9(1));</li> <li>(ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and</li> </ul> </li> <li>(b) a service to which item 723 (performed in accordance with subclause 2.16.9(1)), or item 92025 or 92056 of the Telehealth and Telephone Determination, applies has not been performed in the past 12 months; and</li> <li>(c) the service to which item 230 (performed in accordance with subclause 2.16.9(1)) applies is not performed more than once in a 12 month period; and</li> <li>(d) the service to which item 230 applies: <ul style="list-style-type: none"> <li>(i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and</li> <li>(ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by a medical practitioner</li> </ul> </li> </ul>

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Clause 2.16.12A

**Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233**

Item	Column 1 Item of this Schedule	Column 2 Circumstances
3	230 (if subclause 2.16.9(1A) applies to the item)	<p>The circumstances are that:</p> <ul style="list-style-type: none"><li>(a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items (for coordinating a review of team care arrangements) apply but had not been performed for the patient:<ul style="list-style-type: none"><li>(i) item 233 or 723 (performed in accordance with subclause 2.16.9(1A));</li><li>(ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and</li></ul></li><li>(b) a service to which item 723 (performed in accordance with subclause 2.16.9(1A)), or item 92025 or 92056 of the Telehealth and Telephone Determination, applies has not been performed in the past 12 months; and</li><li>(c) the service to which item 230 (performed in accordance with subclause 2.16.9(1A)) applies is not performed more than once in a 12 month period; and</li><li>(d) the service to which item 230 applies:<ul style="list-style-type: none"><li>(i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and</li><li>(ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by a medical practitioner</li></ul></li></ul>
4	231	<p>The circumstances are that:</p> <ul style="list-style-type: none"><li>(a) either:<ul style="list-style-type: none"><li>(i) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items apply but had not been performed for the patient:<ul style="list-style-type: none"><li>(A) item 232, 233, 731 or 732;</li><li>(B) item 92027, 92028, 92058 or 92059 of the Telehealth and Telephone Determination; or</li></ul></li><li>(ii) in the 12 months before performance of the service, being a service that has not been performed for the patient:<ul style="list-style-type: none"><li>(A) by a medical practitioner who performs the service to which item 231 or 729, or item 92026 or 92057 of the Telehealth and Telephone Determination, would, but for this item, apply; and</li><li>(B) for which a payment has been made under item 229, 230, 721 or 723, or item 92024, 92025, 92055 or 92056 of the Telehealth and Telephone Determination; and</li></ul></li></ul></li><li>(b) a service to which item 729, or item 92026 or 92057 of the Telehealth and Telephone Determination, applies is performed not more than once in a 3 month period; and</li></ul>

**Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233**

Item	Column 1 Item of this Schedule	Column 2 Circumstances
5	232	<p>(c) the service to which item 231 applies is performed not more than once in a 3 month period</p> <p>The circumstances are that:</p> <p>(a) in the 3 months before performance of the service by a prescribed medical practitioner for a patient, being a service to which any of the following items apply but had not been performed for the patient:</p> <p>(i) item 229, 230, 231, 233, 721, 723, 729 or 732;</p> <p>(ii) item 92024, 92025, 92026, 92028, 92055, 92056, 92057 or 92059 of the Telehealth and Telephone Determination; and</p> <p>(b) a service to which item 731, or item 92027 or 92058 of the Telehealth and Telephone Determination, applies is performed not more than once in a 3 month period; and</p> <p>(c) the service to which item 232 applies is performed not more than once in a 3 month period</p>
6	233 (if subclause 2.16.9(1) applies to the item)	<p>The circumstances are that each service may be performed by a prescribed medical practitioner for a patient, if:</p> <p>(a) a service to which any of the following items apply but has not been claimed in the past 3 months:</p> <p>(i) item 732 (performed in accordance with subclause 2.16.9(1);</p> <p>(ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and</p> <p>(b) the service is performed once in a 3 month period; and</p> <p>(c) the service is performed on the same day; and</p> <p>(d) the service:</p> <p>(i) is not performed by a person who is a recognised specialist in palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and</p> <p>(ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by a medical practitioner</p>
7	233 (if subclause 2.16.9(1A) applies to the item)	<p>The circumstances are that each service may be performed by a prescribed medical practitioner for a patient, if:</p> <p>(a) a service to which any of the following items apply but has not been claimed in the past 3 months:</p> <p>(i) item 732 (performed in accordance with subclause 2.16.9(1A);</p> <p>(ii) item 92028 or 92059 of the Telehealth and Telephone Determination; and</p> <p>(b) the service is performed once in a 3 month period; and</p> <p>(c) the service is performed on the same day; and</p> <p>(d) the service:</p> <p>(i) is not performed by a person who is a recognised specialist in</p>

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Clause 2.16.13

**Table 2.16.12A—Conditions relating to timing of services in items 229, 230, 231, 232 and 233**

Item	Column 1 Item of this Schedule	Column 2 Circumstances
		palliative medicine who is treating a palliative patient who has been referred to the prescribed medical practitioner; and (ii) is not a service to which an item in Subgroup 3 or 4 of Group A24 applies because of the treatment of the palliative patient by the medical practitioner

(3) In this clause:

*exceptional circumstances*, for a patient, means there has been a significant change in the patient's clinical condition or care circumstances that necessitates the performance of the service for the patient.

**2.16.13 Items in Subgroup 1 of Group A15**

This clause sets out items in Subgroup 1 of Group A15.

Note: The fees in Group A15 are indexed in accordance with clause 1.3.1.

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

Column 1 Item	Column 2 Description	Column 3 Fee (\$)
<b>Subgroup 1—GP management plans, team care arrangements and multidisciplinary care plans</b>		
721	Attendance by a general practitioner (not including a specialist or consultant physician), for preparation of a GP management plan for a patient (other than a service associated with a service to which any of items 735 to 758 apply)	150.10
723	Attendance by a general practitioner (not including a specialist or consultant physician), to coordinate the development of team care arrangements for a patient (other than a service associated with a service to which any of items 735 to 758 apply)	118.95
729	Contribution by a general practitioner (not including a specialist or consultant physician), to a multidisciplinary care plan prepared by another provider or a review of a multidisciplinary care plan prepared by another provider (other than a service associated with a service to which any of items 735 to 758 apply)	73.25
731	Contribution by a general practitioner (not including a specialist or consultant physician), to: (a) a multidisciplinary care plan for a patient in a residential aged care facility, prepared by that facility, or to a review of such a plan prepared by such a facility; or (b) a multidisciplinary care plan prepared for a patient by another provider before the patient is discharged from a hospital, or to a review of such	73.25

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	a plan prepared by another provider (other than a service associated with a service to which items 735 to 758 apply)	
732	Attendance by a general practitioner (not including a specialist or consultant physician) to review or coordinate a review of: (a) a GP management plan prepared by a general practitioner (or an associated general practitioner) to which item 721 applies; or (b) team care arrangements which have been coordinated by the general practitioner (or an associated general practitioner) to which item 723 applies	74.95

**Subdivision C—Subgroup 2 of Group A15****2.16.14 Meaning of multidisciplinary discharge case conference**

In items 235, 236, 237, 238, 239, 240, 735, 739, 743, 747, 750 and 758:

*multidisciplinary discharge case conference* means a multidisciplinary case conference carried out for a patient before the patient is discharged from a hospital.

**2.16.15 Meaning of organise and coordinate**

In items 235, 236, 237, 735, 739, 743, 820, 822, 823, 825, 826, 828, 830, 832, 834, 835, 837, 838, 855, 857, 858, 861, 864, 866, 930, 933, 935, 946, 948, 959, 969, 971 and 972:

*organise and coordinate*, for a conference mentioned in the item, means undertaking all of the following activities:

- (a) explaining to the patient the nature of the conference;
- (b) asking the patient whether the patient agrees to the conference taking place;
- (c) recording the patient's agreement to the conference;
- (d) recording the day the conference was held and the times the conference started and ended;
- (e) recording the names of the participants;
- (f) recording the activities mentioned in the definition of *multidisciplinary case conference* in clause 1.1.4 and putting a copy of that record in the patient's medical records;
- (g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;

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Clause 2.16.16

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- (h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

**2.16.16 Meaning of participate**

In items 238, 239, 240, 747, 750, 758, 825, 826, 828, 835, 837, 838, 937, 943, 945, 961, 962, 964, 973, 975 and 986:

*participate*, for a conference mentioned in the item, means participation that:

- (a) does not include organising and coordinating the conference; and
- (b) involves undertaking all of the following activities in relation to the conference:
  - (i) explaining to the patient the nature of the conference;
  - (ii) asking the patient whether the patient agrees to the practitioner's participation in the conference;
  - (iii) recording the patient's agreement to the practitioner's participation in the conference;
  - (iv) recording the day the conference was held and the times the conference started and ended;
  - (v) recording the names of the participants;
  - (vi) recording the matters mentioned in the definition of *multidisciplinary case conference* in clause 1.1.4 and putting a copy of that record in the patient's medical records.

**2.16.17 Meaning of coordinating**

In item 880:

*coordinating*, for a case conference, means undertaking all of the following activities:

- (a) coordinating and facilitating the case conference;
- (b) resolving any disagreement or conflict to enable the members of the case conference team giving care and service to the patient to agree on the outcomes to be achieved;
- (c) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team;
- (d) recording the input of each member and the outcome of the case conference.

**2.16.18 Meaning of case conference team**

In item 880:

*case conference team*:

- (a) includes a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine; and
- (b) includes at least 2 other allied health professionals, each of whom provides a different kind of care or service to the patient and is not a medical practitioner or unpaid carer of the patient; and
- (c) may include the patient, an unpaid carer of the patient or a medical practitioner.

Example: For the purposes of paragraph (b), persons who may be included in a team are the following:

- (a) dieticians;
- (b) mental health workers;
- (c) occupational therapists;
- (d) pharmacists;
- (e) physiotherapists;
- (f) podiatrists;
- (g) psychologists;
- (h) social workers;
- (i) speech pathologists.

### 2.16.19 Restrictions on item 880—certain patients

- (1) Item 880 applies if the attendance is on a patient who:
  - (a) is an admitted patient of a hospital; and
  - (b) is not a care recipient in a residential aged care facility; and
  - (c) is being provided with one of the following types of specialist care:
    - (i) geriatric evaluation and management;
    - (ii) rehabilitation care.

- (2) In this clause:

***geriatric evaluation and management*** means care provided to a patient with a disability or psychosocial problem for the purpose of maximising the patient's health status or optimising the patient's living arrangements.

***rehabilitation care*** means care provided to a patient with an impairment or disability for the purpose of improving the patient's functional status.

### 2.16.19A Restrictions on items 930 to 964, 969, 971, 972, 973, 975 and 986

Items 930 to 964, 969, 971, 972, 973, 975 and 986 apply to a patient only if the patient:

- (a) is referred for a service to which any of the following items apply:
  - (i) an item in Subgroup 2 of Group A20;
  - (ii) an item in Subgroup 9 of Group A7;
  - (iii) an item in Subgroup 3 or 10 of Group A40;
  - (iv) an item in Group M6 or M7;
  - (v) an item in Subgroup 1, 2, 3, 4, 6, 7, 8 or 9 of Group M18; or

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Clause 2.16.20

(b) has an eating disorder treatment and management plan.

**2.16.20 Items in Subgroup 2 of Group A15**

This clause sets out items in Subgroup 2 of Group A15.

Note: The fees in Group A15 are indexed in accordance with clause 1.3.1.

<b>Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 2—Case conferences</b>		
735	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply)	73.55
739	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	125.85
743	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to organise and coordinate: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	209.80
747	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or	54.05

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(b) a multidisciplinary case conference carried out for a care recipient in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 15 minutes, but for less than 20 minutes (other than a service associated with a service to which items 721 to 732 apply)	
750	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 20 minutes, but for less than 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	92.60
758	Attendance by a general practitioner (not including a specialist or consultant physician), as a member of a multidisciplinary case conference team, to participate in: (a) a community case conference; or (b) a multidisciplinary case conference carried out for a care recipient in a residential aged care facility; or (c) a multidisciplinary discharge case conference; if the conference lasts for at least 40 minutes (other than a service associated with a service to which items 721 to 732 apply)	154.20
820	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	146.90
822	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	220.45
823	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a community case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	293.70
825	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference	105.50

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## Clause 2.16.20

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	
826	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	168.25
828	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	231.05
830	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	146.90
832	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	220.45
834	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 3 other formal care providers of different disciplines	293.70
835	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	105.50
837	Attendance by a consultant physician in the practice of the consultant physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	168.25
838	Attendance by a consultant physician in the practice of the consultant	231.05

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	physician's specialty, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	
855	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	146.90
857	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	220.45
858	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team	293.70
861	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	146.90
864	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	220.45
866	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	293.70
871	Attendance by a general practitioner, specialist or consultant physician, as a member of a case conference team, to lead and coordinate a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 3 other medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	84.80
872	Attendance by a general practitioner, specialist or consultant physician, as	39.50

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## Clause 2.16.20

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	a member of a case conference team, to participate in a multidisciplinary case conference on a patient with cancer to develop a multidisciplinary treatment plan, if the case conference is of at least 10 minutes, with a multidisciplinary team of at least 4 medical practitioners from different areas of medical practice (which may include general practice), and, in addition, allied health providers	
880	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of geriatric or rehabilitation medicine, as a member of a case conference team, to coordinate a case conference of at least 10 minutes but less than 30 minutes—for any particular patient, one attendance only in a 7 day period (other than attendance on the same day as an attendance for which item 832, 834, 835, 837 or 838 was applicable in relation to the patient) (H)	51.40
930	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes	77.45
933	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes	132.45
935	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference, if the conference lasts for at least 40 minutes	220.80
937	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 15 minutes, but for less than 20 minutes	56.90
943	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 20 minutes, but for less than 40 minutes	97.50
945	Attendance by a general practitioner, as a member of a multidisciplinary case conference team, to participate in a mental health case conference, if the conference lasts for at least 40 minutes	162.30
946	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	154.60
948	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	232.05

**Group A15—GP management plans, team care arrangements and multidisciplinary care plans and case conferences**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
959	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to organise and coordinate a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team	309.15
961	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	111.05
962	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	177.10
964	Attendance by a consultant physician in the practice of the consultant physician's specialty of psychiatry or paediatrics, as a member of a multidisciplinary case conference team, to participate in a mental health case conference of at least 45 minutes, with the multidisciplinary case conference team	243.20

**Division 2.17—Group A17 and Subgroup 7 of Group A7: Domiciliary and residential medication management reviews**

Note: Items in Subgroup 7 of Group A7 are set out in Division 2.10.

**2.17.1 Meaning of living in a community setting**

In items 900 and 245:

***living in a community setting***: a patient is ***living in a community setting*** if the patient is not an in-patient of a hospital or a care recipient in a residential aged care facility.

**2.17.2 Meaning of residential medication management review**

(1) In items 903 and 249:

***residential medication management review*** means a collaborative service provided by a general practitioner (for item 903), or a prescribed medical practitioner (for item 249), and a pharmacist to review the medication management needs of a care recipient in a residential aged care facility.

**Schedule 1** General medical services table

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**Division 2.17** Group A17 and Subgroup 7 of Group A7: Domiciliary and residential medication management reviews

**Clause 2.17.3**

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- (2) A medical practitioner's involvement in a residential medication management review includes all of the following:
  - (a) discussing the proposed review with the resident and seeking the resident's consent to the review;
  - (b) collaborating with the reviewing pharmacist about the pharmacist's involvement in the review;
  - (c) providing input from the resident's most recent comprehensive medical assessment or, if such an assessment has not been undertaken, providing relevant clinical information for the review and for the resident's records;
  - (d) subject to subclause (4), participating in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:
    - (i) the findings of the review; and
    - (ii) medication management strategies; and
    - (iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up;
  - (e) developing or revising the resident's medication management plan after discussion with the reviewing pharmacist, and finalising the plan after discussion with the resident.
- (3) A medical practitioner's involvement in a residential medication management review also includes:
  - (a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and
  - (b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and
  - (c) discussing the plan with nursing staff if necessary.
- (4) A post-review discussion is not required if:
  - (a) there are no recommended changes to the resident's medication management arising out of the review; or
  - (b) any changes are minor in nature and do not require immediate discussion; or
  - (c) the pharmacist and medical practitioner agree that issues arising out of the review should be considered in a case conference.

**2.17.3 Restrictions on items 900, 903, 245 and 249**

*Items 900 and 903*

- (1) Items 900 and 903 apply only to a service provided in the course of personal attendance by a single general practitioner on a single patient.

*Items 245 and 249*

- (2) Items 245 and 249 apply only to a service provided in the course of personal attendance by a single prescribed medical practitioner on a single patient.

### 2.17.4 Items in Group A17

This clause sets out items in Group A17.

Note: The fees in Group A17 are indexed in accordance with clause 1.3.1.

<b>Group A17—Domiciliary and residential medication management reviews</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
900	<p>Participation by a general practitioner (not including a specialist or consultant physician) in a Domiciliary Medication Management Review (<b>DMMR</b>) for a patient living in a community setting, in which the general practitioner, with the patient's consent:</p> <ul style="list-style-type: none"> <li>(a) assesses the patient as: <ul style="list-style-type: none"> <li>(i) having a chronic medical condition or a complex medication regimen; and</li> <li>(ii) not having their therapeutic goals met; and</li> </ul> </li> <li>(b) following that assessment: <ul style="list-style-type: none"> <li>(i) refers the patient to a community pharmacy or an accredited pharmacist for the DMMR; and</li> <li>(ii) provides relevant clinical information required for the DMMR; and</li> </ul> </li> <li>(c) discusses with the reviewing pharmacist the results of the DMMR including suggested medication management strategies; and</li> <li>(d) develops a written medication management plan following discussion with the patient; and</li> <li>(e) provides the written medication management plan to a community pharmacy chosen by the patient</li> </ul> <p>For any particular patient—applicable not more than once in each 12 month period, and only if item 245 does not apply in the same 12 month period, except if there has been a significant change in the patient's condition or medication regimen requiring a new DMMR</p>	161.10
903	<p>Participation by a general practitioner (not including a specialist or consultant physician) in a residential medication management review (<b>RMMR</b>) for a patient who is a care recipient in a residential aged care facility—other than an RMMR for a resident in relation to whom, in the preceding 12 months, this item or item 249 has applied, unless there has been a significant change in the resident's medical condition or medication management plan requiring a new RMMR</p>	110.30

### Division 2.20—Group A20 and Subgroup 9 of Group A7: Mental health care

Note: Items in Subgroup 9 of Group A7 are set out in Division 2.10.

#### 2.20.1 Definitions

In this Schedule:

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Division 2.20 Group A20 and Subgroup 9 of Group A7: Mental health care

Clause 2.20.2

***focussed psychological strategies*** means any of the following mental health care management strategies which have been derived from evidence-based psychological therapies:

- (a) psycho-education;
- (b) cognitive-behavioural therapy which involves cognitive or behavioural interventions;
- (c) relaxation strategies;
- (d) skills training;
- (e) interpersonal therapy;
- (f) eye movement desensitisation and reprocessing.

***mental disorder*** means a significant impairment of any or all of an individual's cognitive, affective and relational abilities that:

- (a) may require medical intervention; and
- (b) may be a recognised, medically diagnosable illness or disorder; and
- (c) is not dementia, delirium, tobacco use disorder or mental retardation.

Note: In relation to this definition, attention is drawn to the *Diagnostic and Management Guidelines for Mental Disorders in Primary Care* (ICD-10, Chapter 5, Primary Care Version), developed by the World Health Organisation and published in 1996.

***outcome measurement tool*** means a tool used to monitor changes in a patient's health that occur in response to treatment received by the patient.

**2.20.2 Meaning of amount under clause 2.20.2**

- (1) In items 2723, 2727, 2741 and 2745:

***amount under clause 2.20.2***, for an item mentioned in column 1 of table 2.20.2, means the sum of:

- (a) the fee mentioned in column 2 for the item; and
- (b) either:
  - (i) if not more than 6 patients are attended at a single attendance—the amount mentioned in column 3 for the item, divided by the number of patients attended; or
  - (ii) if more than 6 patients are attended at a single attendance—the amount mentioned in column 4 for the item.

**Table 2.20.2—Amount under clause 2.20.2**

Item	Column 1 Item of this Schedule	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) (\$)	Column 4 Amount if more than 6 patients (\$)
1	2723	The fee for item 2721	29.60	2.35
2	2727	The fee for item 2725	29.60	2.35
3	2741	The fee for item 2739	29.60	2.35
4	2745	The fee for item 2743	29.60	2.35

- (2) A reference in subclause (1) to an attendance on a patient includes, in relation to an attendance to which item 2741 or 2745 applies, an attendance on a person other than a patient as part of a patient’s treatment.

### 2.20.2A Meaning of amount under clause 2.20.2A

- (1) In an item of this Schedule mentioned in column 1 of table 2.20.2A:

**amount under clause 2.20.2A** means the sum of:

- (a) the fee mentioned in column 2 for the item; and
- (b) either:
  - (i) if a practitioner attends not more than 6 patients in a single attendance—the amount mentioned in column 3 for the item, divided by the number of patients attended; or
  - (ii) if a practitioner attends more than 6 patients in a single attendance—the amount mentioned in column 4 for the item.

**Table 2.20.2A—Amount under clause 2.20.2A**

Item	Column 1 Item of this Schedule	Column 2 Fee	Column 3 Amount if not more than 6 patients (to be divided by the number of patients) (\$)	Column 4 Amount if more than 6 patients (\$)
1	285	The fee for item 283	23.70	1.85
2	287	The fee for item 286	23.70	1.85
3	311	The fee for item 309	23.70	1.85
4	315	The fee for item 313	23.70	1.85

- (2) A reference in subclause (1) to an attendance on a patient includes, in relation to an attendance to which item 311 or 315 applies, an attendance on a person other than a patient as part of a patient’s treatment.

### 2.20.3 Meaning of preparation of a GP mental health treatment plan

- (1) In this Schedule:

**preparation of a GP mental health treatment plan**, for a patient, means each of the following:

- (a) preparation of a written plan by a general practitioner or a prescribed medical practitioner for the patient that includes:
  - (i) an assessment of the patient’s mental disorder, including administration of an outcome measurement tool (except if considered clinically inappropriate); and
  - (ii) formulation of the mental disorder, including provisional diagnosis or diagnosis; and
  - (iii) treatment goals with which the patient agrees; and
  - (iv) any actions to be taken by the patient; and

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- (v) a plan for either or both of the following:
    - (A) crisis intervention;
    - (B) relapse prevention; and
  - (vi) referral and treatment options for the patient; and
  - (vii) arrangements for providing the referral and treatment options mentioned in subparagraph (vi); and
  - (viii) arrangements to review the plan;
  - (b) explaining to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan;
  - (c) recording the plan;
  - (d) recording the patient's agreement to the preparation of the plan;
  - (e) offering the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees):
    - (i) a copy of the plan; and
    - (ii) suitable education about the mental disorder;
  - (f) adding a copy of the plan to the patient's medical records.
- (2) In subparagraph (1)(a)(vi):

***referral and treatment options***, for a patient, includes:

- (a) support services for the patient; and
- (b) psychiatric services for the patient; and
- (c) subject to the applicable limitations:
  - (i) psychological therapies provided to the patient, or to a person other than the patient as part of the patient's treatment, by a clinical psychologist (items 80000 to 80025, 91166, 91167, 91168, 91171, 91181, 91182, 91198 and 91199); and
  - (ii) focussed psychological strategies services provided to the patient, or to a person other than the patient as part of the patient's treatment, by a general practitioner or prescribed medical practitioner mentioned in paragraph 2.20.7(1)(b) to provide those services (items 2721 to 2745, 91818, 91819, 91842, 91843, 91859, 91861, 91864 and 91865); and
  - (iii) focussed psychological strategies services provided to the patient, or to a person other than the patient as part of the patient's treatment, by an allied mental health professional (items 80100 to 80175, 91169, 91170, 91172, 91173, 91174, 91175, 91176, 91177, 91183, 91184, 91185, 91186, 91187, 91188, 91194, 91195, 91196, 91197, 91200, 91201, 91202, 91203, 91204 and 91205); and
  - (iv) focussed psychological strategies services provided to the patient, or to a person other than the patient as part of the patient's treatment, by a prescribed medical practitioner mentioned in paragraph 2.20.7A(1)(b) to provide those services (items 283, 285, 286, 287, 309, 311, 313, 315, 91820, 91821, 91844, 91845, 91862, 91863, 91866, 91867).

#### **2.20.4 Meaning of review of a GP mental health treatment plan**

In this Schedule:

*review of a GP mental health treatment plan* means a process by which a general practitioner or a prescribed medical practitioner:

- (a) reviews the matters mentioned in paragraph (a) of the definition of *preparation of a GP mental health treatment plan* in subclause 2.20.3(1); and
- (b) checks, reinforces and expands any education given under the plan; and
- (c) if appropriate and if not previously provided—prepares a plan for either or both of the following:
  - (i) crisis intervention;
  - (ii) relapse prevention;
- (d) re-administers the outcome measurement tool used in the assessment mentioned in subparagraph (a)(i) of the definition of *preparation of a GP mental health treatment plan* in subclause 2.20.3(1) (except if considered clinically inappropriate); and
- (e) if different arrangements need to be made—makes amendments to the plan that state those new arrangements; and
- (f) explains to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review of the plan; and
- (g) records the patient’s agreement to the review of the plan; and
- (h) if amendments are made to the plan:
  - (i) offers a copy of the amended plan to the patient and the patient’s carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
  - (ii) adds a copy of the amended plan to the patient’s medical records.

#### **2.20.5 Meaning of associated general practitioner and associated medical practitioner**

- (1) In item 2712:

*associated general practitioner* means a general practitioner (not including a specialist or consultant physician) who, if not engaged in the same general practice as the general practitioner mentioned in that item, performs the service described in the item at the request of the patient (or the patient’s guardian).

- (2) In item 277:

*associated medical practitioner* means a medical practitioner who, if not engaged in the same general practice as the prescribed medical practitioner mentioned in the item, performs the service described in the item at the request of the patient (or the patient’s guardian).

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**2.20.6 Restrictions on items in Subgroup 1 of Group A20 and Subgroup 9 of Group A7 (GP mental health treatment plans)**

*Patients provided with certain services*

- (1) Items 2700, 2701, 2712, 2713, 2715, 2717, 272, 276, 277, 279, 281 and 282 apply only to a patient with a mental disorder.
- (2) Items 2700, 2701, 2712, 2715, 2717, 272, 276, 277, 281 and 282 apply only to:
  - (a) a patient in the community; and
  - (b) a private in-patient (including a private in-patient who is a resident of an aged care facility) being discharged from hospital; and
  - (c) a service provided in the course of personal attendance by a single medical practitioner on a single patient.

*Timing of certain services—items 2700, 2701, 2715 and 2717*

- (3) Unless exceptional circumstances exist, items 2700, 2701, 2715 and 2717 cannot be claimed:
  - (a) with a service to which items 735 to 758, or item 2713 apply; or
  - (b) more than once in a 12 month period from the provision of any of the items for a particular patient.

*Item 2712*

- (4) Item 2712 applies only if one of the following services has been provided to the patient:
  - (a) the preparation of a GP mental health treatment plan under item 2700, 2701, 2715, 2717, 92112, 92113, 92116 or 92117;
  - (b) a psychiatrist assessment and management plan under item 291.
- (5) Item 2712 does not apply:
  - (a) to a service to which items 735 to 758, or item 2713 apply; or
  - (b) unless exceptional circumstances exist for the provision of the service:
    - (i) more than once in a 3 month period; or
    - (ii) within 4 weeks following the preparation of a GP mental health treatment plan (item 2700, 2701, 2715 or 2717).

*Item 2713*

- (7) Item 2713 does not apply in association with a service to which item 2700, 2701, 2715, 2717 or 2712 applies.

*Items 2715 and 2717—practitioner training*

- (8) Items 2715 and 2717 apply only if the general practitioner providing the service has successfully completed mental health skills training.

*Timing of certain services—items 272, 276, 281 and 282*

- (8A) Unless exceptional circumstances exist, items 272, 276, 281 and 282 cannot be claimed:
- (a) with a service to which any of the following apply:
    - (i) items 235 to 240, 279, 735 to 758 and 2713;
    - (ii) items 92115, 92121 and 92133 of the Telehealth and Telephone Determination; or
  - (b) more than once in a 12 month period from the provision of any of the items for a particular patient; or
  - (c) within 3 months following the provision of a service to which item 277 or 2712, or item 92114, 92120, 92126 or 92132 of the Telehealth and Telephone Determination, applies; or
  - (d) more than once in a 12 month period from the provision of any of items 92118, 92119, 92122 or 92123 of the Telehealth and Telephone Determination.

*Item 277*

- (8B) Item 277 applies only if one of the following services has been provided to the patient:
- (a) the preparation of a GP mental health treatment plan under any of the following:
    - (i) item 272, 276, 281, 282, 2700, 2701, 2715 or 2717;
    - (ii) item 92112, 92113, 92116, 92117, 92118, 92119, 92122 or 92123 of the Telehealth and Telephone Determination;
  - (b) a psychiatrist assessment and management plan under item 291, or item 92435 or 92475 of the Telehealth and Telephone Determination.
- (8C) Item 277 does not apply:
- (a) to a service to which any of the following apply:
    - (i) item 235, 236, 237, 238, 239 240 or 279;
    - (ii) item 735, 739, 743, 747, 750 or 758;
    - (iii) item 2713;
    - (iv) item 92121, 92133, 92115 or 92127 of the Telehealth and Telephone Determination; or
  - (b) unless exceptional circumstances exist for the provision of the service:
    - (i) more than once in a 3 month period; or
    - (ii) within 4 weeks following the preparation of a GP mental health treatment plan under any of the following:
      - (A) item 272, 276, 281, 282, 2700, 2701, 2715 or 2717;
      - (B) item 92112, 92113, 92116, 92117, 92118, 92119, 92122 or 92123 of the Telehealth and Telephone Determination.

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*Item 279*

- (8D) Item 279 does not apply in association with a service to which any of the following apply:
- (a) item 272, 276, 277, 281, 282, 2700, 2701, 2715, 2717 or 2712;
  - (b) item 92112, 92113, 92114, 92116, 92117, 92118, 92119, 92120, 92122, 92123 or 92132 of the Telehealth and Telephone Determination.

*Items 281 and 282—practitioner training*

- (8E) Items 281 and 282 apply only if the prescribed medical practitioner providing the service has successfully completed mental health skills training.

*Definition*

- (9) In this clause:

***exceptional circumstances*** means a significant change in:

- (a) the patient's clinical condition; or
- (b) the patient's care circumstances.

**2.20.7 Restrictions on items in Subgroup 2 of Group A20 (focussed psychological strategies)**

- (1) An item in Subgroup 2 of Group A20 applies to a service which:
- (a) is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and
  - (b) is provided by a general practitioner:
    - (i) whose name is entered in the register maintained by the Chief Executive Medicare under section 33 of the *Human Services (Medicare) Regulations 2017*; and
    - (ii) who is identified in the register as a medical practitioner who can provide services to which Subgroup 2 of Group A20 applies; and
    - (iii) who meets any training and skills requirements, as determined by the General Practice Mental Health Standards Collaboration for providing services to which Subgroup 2 of Group A20 applies.
- (2) An item in Subgroup 2 of Group A20 does not apply to:
- (a) a service which:
    - (i) is provided to a patient, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 6 other services to which any of the items in Subgroup 2 of Group A20 apply have already been provided to or in relation to the patient; and
    - (ii) is provided before the medical practitioner managing the GP mental health treatment plan or the psychiatrist assessment and management plan has conducted a patient review and recorded in the patient's records a recommendation that the patient have additional sessions of focussed psychological strategies in the same calendar year; or

- (b) a service which is provided to a patient, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 10 other services to which an item in Subgroup 2 of Group A20, or item 283, 285, 286, 287, 309, 311, 313, 315, 80000 to 80016, 80100 to 80116, 80125 to 80141, 80150 to 80166, 91166, 91167, 91168, 91169, 91170, 91171, 91172, 91173, 91174, 91175, 91176, 91177, 91181, 91182, 91183, 91184, 91185, 91186, 91187, 91188, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867, apply, have already been provided to or in relation to the patient.
- (3) In addition to the restrictions in subclauses (1) and (2) of this clause, item 2739, 2741, 2743 or 2745 applies to a service provided by a general practitioner to a person other than the patient only if:
- (a) the general practitioner determines it is clinically appropriate to provide focussed psychological strategies services to a person other than the patient, and makes a written record of this determination in the patient's records; and
  - (b) the general practitioner:
    - (i) explains the service to the patient; and
    - (ii) obtains the patient's consent for the service to be provided to the other person as part of the patient's treatment; and
    - (iii) makes a written record of the consent; and
  - (c) the service is provided as part of the patient's treatment; and
  - (d) the patient is not in attendance during the provision of the service; and
  - (e) in the calendar year, no more than one other service to which any of items 309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867 apply has already been provided to or in relation to the patient.

Note: The patient's consent may be withdrawn at any time.

### **2.20.7A Restrictions on items in Subgroup 9 of Group A7 (focussed psychological strategies)**

- (1) Items 283, 285, 286, 287, 309, 311, 313 and 315 apply to a service which:
- (a) is clinically indicated under a GP mental health treatment plan or a psychiatrist assessment and management plan; and
  - (b) is provided by a prescribed medical practitioner:
    - (i) whose name is entered in the register maintained by the Chief Executive Medicare under section 33 of the *Human Services (Medicare) Regulations 2017*; and

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- (ii) who is identified in the register as a medical practitioner who can provide services to which item 283, 285, 286, 287, 309, 311, 313 or 315, or an item in Subgroup 2 of Group A20, applies; and
  - (iii) who meets any training and skills requirements, as determined by the General Practice Mental Health Standards Collaboration, for providing services to which item 283, 285, 286, 287, 309, 311, 313 or 315, or an item in Subgroup 2 of Group A20, applies.
- (2) Items 283, 285, 286, 287, 309, 311, 313 and 315 do not apply to:
  - (a) a service which:
    - (i) is provided by a prescribed medical practitioner to a patient, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 6 other services to which any of the following items apply have already been provided to the patient or to the person:
      - (A) item 283, 285, 286, 287 309, 311, 313 or 315;
      - (B) an item in Subgroup 2 of Group A20;
      - (C) item 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867 of the Telehealth and Telephone Determination applies; or
    - (ii) is provided before the prescribed medical practitioner managing the GP mental health treatment plan or the psychiatrist assessment and management plan has conducted a patient review and recorded in the patient's records a recommendation that the patient have additional sessions of focussed psychological strategies in the same calendar year; or
  - (b) a service which is provided to a patient, or to a person other than the patient as part of the patient's treatment, if, in the calendar year, 10 other services to which any of the following items apply have already been provided to the patient or to the person:
    - (i) item 283, 285, 286, 287, 309, 311, 313, 315, 80000 to 80016, 80100 to 80116, 80125 to 80141, 80150 to 80166, 91166, 91167, 91168, 91169, 91170, 91171, 91172, 91173, 91174, 91175, 91176, 91177, 91181, 91182, 91183, 91184, 91185, 91186, 91187, 91188, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867;
    - (ii) an item in Subgroup 2 of Group A20.
- (3) In addition to the restrictions in subclauses (1) and (2) of this clause, item 309, 311, 313 or 315 applies to a service provided by a prescribed medical practitioner to a person other than the patient only if:
  - (a) the prescribed medical practitioner determines it is clinically appropriate to provide focussed psychological strategies services to a person other than the patient, and makes a written record of this determination in the patient's records; and
  - (b) the prescribed medical practitioner:

- (i) explains the service to the patient; and
- (ii) obtains the patient’s consent for the service to be provided to the other person as part of the patient’s treatment; and
- (iii) makes a written record of the consent; and
- (c) the service is provided as part of the patient’s treatment; and
- (d) the patient is not in attendance during the provision of the service; and
- (e) in the calendar year, no more than one other service to which item 309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91859, 91861, 91862, 91863, 91864, 91865, 91866 or 91867 applies has already been provided to or in relation to the patient.

Note: The patient’s consent may be withdrawn at any time.

### 2.20.8 Items in Group A20

This clause sets out items in Group A20.

Note: The fees in Group A20 are indexed in accordance with clause 1.3.1.

<b>Group A20—Mental health care</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—GP mental health treatment plans</b>		
2700	Professional attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), lasting at least 20 minutes, but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	74.60
2701	Professional attendance, by a general practitioner who has not undertaken mental health skills training (and not including a specialist or consultant physician), lasting at least 40 minutes for the preparation of a GP mental health treatment plan for a patient	109.85
2712	Professional attendance by a general practitioner (not including a specialist or consultant physician) to review a GP mental health treatment plan which the general practitioner, or an associated general practitioner has prepared, or to review a Psychiatrist Assessment and Management Plan	74.60
2713	Professional attendance at consulting rooms by a general practitioner (not including a specialist or consultant physician) in relation to a mental disorder and lasting at least 20 minutes, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation	74.60
2715	Professional attendance, by a general practitioner who has undertaken	94.75

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## Clause 2.20.8

<b>Group A20—Mental health care</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	mental health skills training (but not including a specialist or consultant physician), lasting at least 20 minutes, but less than 40 minutes, for the preparation of a GP mental health treatment plan for a patient	
2717	Professional attendance, by a general practitioner who has undertaken mental health skills training (but not including a specialist or consultant physician), lasting at least 40 minutes for the preparation of a GP mental health treatment plan for a patient	139.55
<b>Subgroup 2—Focussed psychological strategies</b>		
2721	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	96.50
2723	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes	Amount under clause 2.20.2
2725	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	138.10
2727	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician), for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service, and lasting at least 40 minutes	Amount under clause 2.20.2
2739	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient's treatment; and (b) lasting at least 30 minutes, but less than 40 minutes	98.05
2741	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service:	Amount under clause 2.20.2

<b>Group A20—Mental health care</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient’s treatment; and (b) lasting at least 30 minutes, but less than 40 minutes	
2743	Professional attendance at consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient’s treatment; and (b) lasting at least 40 minutes	140.30
2745	Professional attendance at a place other than consulting rooms by a general practitioner (not including a specialist or a consultant physician) registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service: (a) for providing focussed psychological strategies to a person other than the patient, if the service is part of the patient’s treatment; and (b) lasting at least 40 minutes	Amount under clause 2.20.2

## **Division 2.21—Group A24: Palliative and pain medicine**

### **2.21.1 Meaning of organise and coordinate**

In the items in Subgroups 2 and 4 of Group A24:

***organise and coordinate***, for a conference mentioned in the item, means undertaking all of the following activities:

- (a) explaining to the patient the nature of the conference;
- (b) asking the patient whether the patient agrees to the conference taking place;
- (c) recording the patient’s agreement to the conference;
- (d) recording the day the conference was held and the times the conference started and ended;
- (e) recording the names of the participants;
- (f) recording the activities mentioned in the definition of ***multidisciplinary case conference*** in clause 1.1.4 and putting a copy of that record in the patient’s medical records;
- (g) offering the patient and the patient’s carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
- (h) discussing the outcomes of the conference with the patient and the patient’s carer (if any and if the practitioner considers appropriate and the patient agrees).

Clause 2.21.2

**2.21.2 Meaning of participate**

In items 2958, 2972, 2974, 2992, 2996, 3000, 3051, 3055, 3062, 3083, 3088 and 3093:

*participate*, for a conference mentioned in the item, means participation that:

- (a) if the conference is a community case conference—is at the request of the person who organises and coordinates the conference; and
- (b) involves undertaking all of the following activities in relation to the conference:
  - (i) explaining to the patient the nature of the conference;
  - (ii) asking the patient whether the patient agrees to the practitioner’s participation in the conference;
  - (iii) recording the patient’s agreement to the practitioner’s participation in the conference;
  - (iv) recording the day the conference was held and the times the conference started and ended;
  - (v) recording the names of the participants;
  - (vi) recording the activities mentioned in the definition of *multidisciplinary case conference* in clause 1.1.4 and putting a copy of that record in the patient’s medical records; but
- (c) if the conference is a community case conference—does not include organising and coordinating the conference.

**2.21.3 Restrictions on items in Subgroups 2 and 4 of Group A24—timing**

The items in Subgroups 2 and 4 of Group A24 may only apply to a patient 5 times in a 12 month period.

**2.21.4 Items in Group A24**

This clause sets out items in Group A24.

Note: The fees in Group A24 are indexed in accordance with clause 1.3.1.

<b>Group A24—Palliative and pain medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Pain medicine attendances</b>		
2801	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist’s or consultant physician’s specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	159.35
2806	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist’s or consultant physician’s specialty of pain medicine following referral of the patient	79.75

<b>Group A24—Palliative and pain medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 2814 applies) after the initial attendance in a single course of treatment	
2814	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	45.40
2824	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	193.35
2832	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 2840 applies) after the initial attendance in a single course of treatment	116.95
2840	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	84.25
<b>Subgroup 2—Pain medicine case conferences</b>		
2946	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	146.90
2949	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes	220.45
2954	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	293.70
2958	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate	105.50

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.21** Group A24: Palliative and pain medicine

Clause 2.21.4

<b>Group A24—Palliative and pain medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	the conference) of at least 15 minutes but less than 30 minutes	
2972	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes	168.25
2974	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	231.05
2978	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	146.90
2984	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	220.45
2988	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	293.70
2992	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	105.50
2996	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	168.25
3000	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of pain medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	231.05

<b>Group A24—Palliative and pain medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 3—Palliative medicine attendances</b>		
3005	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	159.35
3010	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 3014 applies) after the initial attendance in a single course of treatment	79.75
3014	Professional attendance at consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	45.40
3018	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—initial attendance in a single course of treatment	193.35
3023	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—an attendance (other than a service to which item 3028 applies) after the initial attendance in a single course of treatment	116.95
3028	Professional attendance at a place other than consulting rooms or hospital by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine following referral of the patient to the specialist or consultant physician by a referring practitioner—minor attendance	84.25
<b>Subgroup 4—Palliative medicine case conferences</b>		
3032	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes	146.90
3040	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 30	220.45

Schedule 1 General medical services table

Part 2 Attendances

Division 2.21 Group A24: Palliative and pain medicine

Clause 2.21.4

<b>Group A24—Palliative and pain medicine</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	minutes but less than 45 minutes	
3044	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a community case conference of at least 45 minutes	293.70
3051	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes	105.50
3055	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least 2 other formal care providers of different disciplines	168.25
3062	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes	231.05
3069	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 15 minutes but less than 30 minutes, before the patient is discharged from a hospital (H)	146.90
3074	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to organise and coordinate a discharge case conference of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	220.45
3078	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to organise and coordinate a discharge case conference of at least 45 minutes, before the patient is discharged from a hospital (H)	293.70
3083	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, before the	105.50

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**Group A24—Palliative and pain medicine**

Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	patient is discharged from a hospital (H)	
3088	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, before the patient is discharged from a hospital (H)	168.25
3093	Attendance by a specialist, or consultant physician, in the practice of the specialist's or consultant physician's specialty of palliative medicine, as a member of a multidisciplinary case conference team, to participate in a discharge case conference (other than to organise and coordinate the conference) of at least 45 minutes, before the patient is discharged from a hospital (H)	231.05

**Division 2.22—Group A27 and Subgroup 11 of Group A7: Pregnancy support counselling**

Note: Items in Subgroup 11 of Group A7 are set out in Division 2.10.

**2.22.1 Restrictions on items 4001 and 792**

- (1) A service to which item 4001 applies must not be provided by a general practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.
- (1A) A service to which item 792 applies must not be provided by a prescribed medical practitioner who has a direct pecuniary interest in a health service that has as its primary purpose the provision of services for pregnancy termination.
- (2) Items 4001 and 792 do not apply if a patient has already been provided, for the same pregnancy, with 3 services to which that item or item 81000, 81005 or 81010 applies.

Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act.

- (3) In items 4001 and 729:

***non-directive pregnancy support counselling*** means counselling provided by a general practitioner (for item 4001) or a prescribed medical practitioner (for item 729) to a patient in which:

- (a) information and issues relating to pregnancy are discussed; and
- (b) the medical practitioner does not impose the medical practitioner's views or values about what the patient should or should not do in relation to the pregnancy.

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.23** Group A21: Professional attendances at recognised emergency departments of private hospitals

Clause 2.22.2

- (4) A service to which item 4001 or 729 applies may be used to address any pregnancy-related issue.

**2.22.2 Items in Group A27**

This clause sets out items in Group A27.

Note: The fees in Group A27 are indexed in accordance with clause 1.3.1.

**Group A27—Pregnancy support counselling**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
4001	Professional attendance lasting at least 20 minutes at consulting rooms by a general practitioner (not including a specialist or consultant physician) who is registered with the Chief Executive Medicare as meeting the credentialling requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a patient who: (a) is currently pregnant; or (b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy	79.70
	Note: For items 81000, 81005 and 81010, see the determination about allied health services under subsection 3C(1) of the Act.	

**Division 2.23—Group A21: Professional attendances at recognised emergency departments of private hospitals**

**2.23.1 Items in Group A21**

This clause sets out items in Group A21.

Note: The fees in Group A21 are indexed in accordance with clause 1.3.1.

**Group A21—Professional attendances at recognised emergency departments of private hospitals**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
<b>Subgroup 1—Consultations</b>		
5001	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	61.05
5004	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	102.50

<b>Group A21—Professional attendances at recognised emergency departments of private hospitals</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
5011	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of ordinary complexity	102.50
5012	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	160.70
5013	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	202.15
5014	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of complexity that is more than ordinary but is not high	202.15
5016	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	271.25
5017	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	312.80
5019	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine involving medical decision-making of high complexity	312.80
5021	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	45.75
5022	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of ordinary complexity	76.90
5027	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's	76.90

**Schedule 1** General medical services table**Part 2** Attendances**Division 2.23** Group A21: Professional attendances at recognised emergency departments of private hospitals

## Clause 2.23.1

<b>Group A21—Professional attendances at recognised emergency departments of private hospitals</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	specialty of emergency medicine) involving medical decision-making of ordinary complexity	
5030	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	120.45
5031	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	151.60
5032	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of complexity that is more than ordinary but is not high	151.60
5033	Professional attendance, on a patient at least 4 years old but under 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	203.45
5035	Professional attendance, on a patient under 4 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	234.60
5036	Professional attendance, on a patient at least 75 years old, at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) involving medical decision-making of high complexity	234.60
<b>Subgroup 2—Prolonged professional attendances to which no other Group applies</b>		
5039	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: (a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and (b) the attendance is the initial attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and (c) the attendance is in conjunction with, or after, an attendance on the	148.25

<b>Group A21—Professional attendances at recognised emergency departments of private hospitals</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019	
5041	Professional attendance at a recognised emergency department of a private hospital by a specialist in the practice of the specialist's specialty of emergency medicine for preparation of goals of care by the specialist for a gravely ill patient lacking current goals of care if: <ul style="list-style-type: none"> <li>(a) the specialist takes overall responsibility for the preparation of the goals of care for the patient; and</li> <li>(b) the attendance is the initial attendance by the specialist for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and</li> <li>(c) the attendance is not in conjunction with, or after, an attendance on the patient by the specialist that is described in item 5001, 5004, 5011, 5012, 5013, 5014, 5016, 5017 or 5019; and</li> <li>(d) the attendance is for at least 60 minutes</li> </ul>	278.75
5042	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: <ul style="list-style-type: none"> <li>(a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and</li> <li>(b) the attendance is the initial attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and</li> <li>(c) the attendance is in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036</li> </ul>	111.25
5044	Professional attendance at a recognised emergency department of a private hospital by a medical practitioner (except a specialist in the practice of the specialist's specialty of emergency medicine) for preparation of goals of care by the practitioner for a gravely ill patient lacking current goals of care if: <ul style="list-style-type: none"> <li>(a) the practitioner takes overall responsibility for the preparation of the goals of care for the patient; and</li> <li>(b) the attendance is the initial attendance by the practitioner for the preparation of the goals of care for the patient following the presentation of the patient to the emergency department; and</li> <li>(c) the attendance is not in conjunction with, or after, an attendance on the patient by the practitioner that is described in item 5021, 5022, 5027, 5030, 5031, 5032, 5033, 5035 or 5036; and</li> <li>(d) the attendance is for at least 60 minutes</li> </ul>	209.00

Schedule 1 General medical services table

Part 2 Attendances

Division 2.24 Group A22: General practitioner after-hours attendances to which no other item applies

Clause 2.24.1

**Division 2.24—Group A22: General practitioner after-hours attendances to which no other item applies**

**2.24.1 Restrictions on items in Group A22—timing**

- (1) Items 5000, 5020, 5040, 5060 and 5071 apply only to a professional attendance that is provided:
  - (a) on a public holiday; or
  - (b) on a Sunday; or
  - (c) before 8 am, or after 1 pm, on a Saturday; or
  - (d) before 8 am, or after 8 pm, on a day other than a day mentioned in paragraphs (a) to (c).
- (2) Items 5003, 5010, 5023, 5028, 5043, 5049, 5063, 5067, 5076 and 5077 apply only to a professional attendance that is provided in an after-hours period.

**2.24.2 Items in Group A22**

This clause sets out items in Group A22.

Note: The fees in Group A22 are indexed in accordance with clause 1.3.1.

<b>Group A22—General practitioner after-hours attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
5000	Professional attendance at consulting rooms (other than a service to which another item applies) by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management	30.15
5003	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies) that requires a short patient history and, if necessary, limited examination and management—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5010	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5020	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies),	51.00

**Group A22—General practitioner after-hours attendances to which no other item applies**

<b>Column 1</b> <b>Item</b>	<b>Column 2</b> <b>Description</b>	<b>Column 3</b> <b>Fee (\$)</b>
	lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	
5023	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5028	Professional attendance by a general practitioner (other than a service to which another item in this Schedule applies), on care recipients in a residential aged care facility, lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5040	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care;	87.40

Schedule 1 General medical services table

Part 2 Attendances

Division 2.24 Group A22: General practitioner after-hours attendances to which no other item applies

Clause 2.24.2

<b>Group A22—General practitioner after-hours attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	for one or more health-related issues, with appropriate documentation	
5043	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5049	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5060	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	122.55
5063	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history;	Amount under clause 2.1.1

**Group A22—General practitioner after-hours attendances to which no other item applies**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	
5067	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5071	Professional attendance by a general practitioner at consulting rooms (other than a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation	220.25
5076	Professional attendance by a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1

Schedule 1 General medical services table

Part 2 Attendances

Division 2.25 Group A23: Other non-referred after-hours attendances to which no other item applies

Clause 2.25.1

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<b>Group A22—General practitioner after-hours attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
5077	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item in this Schedule applies, lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

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**Division 2.25—Group A23: Other non-referred after-hours attendances to which no other item applies**

**2.25.1 Restrictions on items in Group A23—timing**

- (1) Items 5200, 5203, 5207, 5208 and 5209 apply only to a professional attendance that is provided:
  - (a) on a public holiday; or
  - (b) on a Sunday; or
  - (c) before 8 am, or after 1 pm, on a Saturday; or
  - (d) before 8 am, or after 8 pm, on a day other than a day mentioned in paragraphs (a) to (c).
- (2) Items 5220 to 5267 apply only to a professional attendance that is provided in an after-hours period.

**2.25.2 Items in Group A23**

This clause sets out items in Group A23.

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<b>Group A23—Other non-referred after-hours attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
5200	Professional attendance at consulting rooms lasting not more than 5 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	21.00
5203	Professional attendance at consulting rooms lasting more than 5 minutes, but not more than 25 minutes, (other than a service to which another	31.00

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<b>Group A23—Other non-referred after-hours attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	item applies) by a medical practitioner (other than a general practitioner)	
5207	Professional attendance at consulting rooms lasting more than 25 minutes, but not more than 45 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	48.00
5208	Professional attendance at consulting rooms lasting more than 45 minutes, but not more than 60 minutes, (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	71.00
5209	Professional attendance at consulting rooms lasting more than 60 minutes (other than a service to which another item applies) by a medical practitioner (other than a general practitioner)	122.40
5220	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting not more than 5 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5223	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5227	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5228	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting more than 45 minutes, but not more than 60 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5261	Professional attendance by a medical practitioner who is not a general practitioner (other than attendance at consulting rooms, a hospital or a residential aged care facility or a service to which another item in this Schedule applies), lasting more than 60 minutes—an attendance on one or more patients on one occasion—each patient	Amount under clause 2.1.1
5260	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit,	Amount under clause 2.1.1

Schedule 1 General medical services table

Part 2 Attendances

Division 2.26 Group A26: Neurosurgery attendances to which no other item applies

Clause 2.26.1

<b>Group A23—Other non-referred after-hours attendances to which no other item applies</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	lasting not more than 5 minutes by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	
5263	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 5 minutes, but not more than 25 minutes, by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5265	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 25 minutes, but not more than 45 minutes, by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5267	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes, but not more than 60 minutes, by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1
5262	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient at the facility and is not a resident of a self-contained unit, lasting more than 60 minutes by a medical practitioner (other than a general practitioner)—an attendance on one or more patients at one residential aged care facility on one occasion—each patient	Amount under clause 2.1.1

**Division 2.26—Group A26: Neurosurgery attendances to which no other item applies**

**2.26.1 Items in Group A26**

This clause sets out items in Group A26.

Note: The fees in Group A26 are indexed in accordance with clause 1.3.1.

<b>Group A26—Neurosurgery attendances to which no other item applies</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
6007	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an initial attendance in a single course of treatment at consulting rooms or hospital	136.85
6009	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—minor attendance at consulting rooms or hospital	45.40
6011	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, involving an extensive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and lasting more than 15 minutes, but not more than 30 minutes, at consulting rooms or hospital	90.35
6013	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, involving a detailed and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and lasting more than 30 minutes, but not more than 45 minutes, at consulting rooms or hospital	125.15
6015	Professional attendance by a specialist practising in the specialist's specialty of neurosurgery following referral of the patient to the specialist—an attendance after the initial attendance in a single course of treatment, involving an exhaustive and comprehensive examination, arranging any necessary investigations in relation to one or more complex problems and lasting more than 45 minutes at consulting rooms or hospital	159.35

## **Division 2.27—Group A31: Addiction medicine**

### **2.27.1 Meaning of organise and coordinate**

In items 6029 to 6042:

***organise and coordinate***, for a conference mentioned in the item, means undertaking all of the following activities:

- (a) explaining to the patient the nature of the conference;
- (b) asking the patient whether the patient agrees to the conference taking place;
- (c) recording the patient's agreement to the conference;

### Clause 2.27.2

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- (d) recording the day the conference was held and the times the conference started and ended;
- (e) recording the names of the participants;
- (f) recording the activities mentioned in the definition of **multidisciplinary case conference** in clause 1.1.4 and putting a copy of that record in the patient's medical records;
- (g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
- (h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

#### 2.27.2 Meaning of participate

In items 6035 to 6042:

**participate**, for a conference mentioned in the item, means participation that:

- (a) does not include organising and coordinating the conference; and
- (b) involves undertaking all of the following activities in relation to the conference:
  - (i) explaining to the patient the nature of the conference;
  - (ii) asking the patient whether the patient agrees to the practitioner's participation in the conference;
  - (iii) recording the patient's agreement to the practitioner's participation in the conference;
  - (iv) recording the day the conference was held and the times the conference started and ended;
  - (v) recording the names of the participants;
  - (vi) recording the activities mentioned in the definition of **multidisciplinary case conference** in clause 1.1.4 and putting a copy of that record in the patient's medical records.

#### 2.27.3 Restrictions on item 6028

Item 6028 applies only to a service provided in the course of a personal attendance by a single addiction medicine specialist.

#### 2.27.4 Items in Group A31

This clause sets out items in Group A31.

Note: The fees in Group A31 are indexed in accordance with clause 1.3.1.

<b>Group A31—Addiction medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Addiction medicine attendances</b>		
6018	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist’s specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	159.35
6019	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist’s specialty following referral of the patient to the addiction medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6018 in a single course of treatment; or (b) that follows an initial assessment under item 6023 in a single course of treatment; or (c) that follows a review under item 6024 in a single course of treatment	79.75
6023	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist’s specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the addiction medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) an addiction medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same addiction medicine specialist	278.75
6024	Professional attendance by an addiction medicine specialist in the practice of the addiction medicine specialist’s specialty of at least 20 minutes, after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities if:	139.55

Schedule 1 General medical services table  
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Division 2.27 Group A31: Addiction medicine

Clause 2.27.4

<b>Group A31—Addiction medicine</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<p>(a) a review is undertaken that covers:</p> <ul style="list-style-type: none"> <li>(i) review of initial presenting problems and results of diagnostic investigations; and</li> <li>(ii) review of responses to treatment and medication plans initiated at time of initial consultation; and</li> <li>(iii) comprehensive multi or detailed single organ system assessment; and</li> <li>(iv) review of original and differential diagnoses; and</li> </ul> <p>(b) the modified addiction medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate:</p> <ul style="list-style-type: none"> <li>(i) a revised opinion on diagnosis and risk assessment; and</li> <li>(ii) treatment options and decisions; and</li> <li>(iii) revised medication recommendations; and</li> </ul> <p>(c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6018 or 6019 applies did not take place on the same day by the same addiction medicine specialist; and</p> <p>(d) item 6023 applied to an attendance claimed in the preceding 12 months; and</p> <p>(e) the attendance under this item is claimed by the same addiction medicine specialist who claimed item 6023 or by a locum tenens; and</p> <p>(f) this item has not applied more than twice in any 12 month period</p>	
<b>Subgroup 2—Group therapy</b>		
6028	Group therapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hour, given under the continuous direct supervision of an addiction medicine specialist in the practice of the addiction medicine specialist's specialty for a group of 2 to 9 unrelated patients, or a family group of more than 2 patients, each of whom is referred to the addiction medicine specialist by a referring practitioner—for each patient	52.05
<b>Subgroup 3—Addiction medicine case conferences</b>		
6029	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	45.10
6031	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	79.75

<b>Group A31—Addiction medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
6032	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	119.65
6034	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate the multidisciplinary case conference of at least 45 minutes, with the multidisciplinary case conference team	159.35
6035	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team	36.05
6037	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	63.80
6038	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	95.70
6042	Attendance by an addiction medicine specialist in the practice of the addiction medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	127.50

## **Division 2.28—Group A32: Sexual health medicine**

### **2.28.1 Meaning of organise and coordinate**

In items 6064 to 6075:

### Clause 2.28.2

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**organise and coordinate**, for a conference mentioned in the item, means undertaking all of the following activities:

- (a) explaining to the patient the nature of the conference;
- (b) asking the patient whether the patient agrees to the conference taking place;
- (c) recording the patient's agreement to the conference;
- (d) recording the day the conference was held and the times the conference started and ended;
- (e) recording the names of the participants;
- (f) recording the activities mentioned in the definition of **multidisciplinary case conference** in clause 1.1.4 and putting a copy of that record in the patient's medical records;
- (g) offering the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees), and giving each other member of the team, a summary of the conference;
- (h) discussing the outcomes of the conference with the patient and the patient's carer (if any and if the practitioner considers appropriate and the patient agrees).

### 2.28.2 Meaning of participate

In items 6071 to 6075:

**participate**, for a conference mentioned in the item, means participation that:

- (a) does not include organising and coordinating the conference; and
- (b) involves undertaking all of the following activities in relation to the conference:
  - (i) explaining to the patient the nature of the conference;
  - (ii) asking the patient whether the patient agrees to the practitioner's participation in the conference;
  - (iii) recording the patient's agreement to the practitioner's participation in the conference;
  - (iv) recording the day the conference was held and the times the conference started and ended;
  - (v) recording the names of the participants;
  - (vi) recording the activities mentioned in the definition of **multidisciplinary case conference** in clause 1.1.4 and putting a copy of that record in the patient's medical records.

### 2.28.3 Items in Group A32

This clause sets out items in Group A32.

Note: The fees in Group A32 are indexed in accordance with clause 1.3.1.

<b>Group A32—Sexual health medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Sexual health medicine attendances</b>		
6051	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist’s specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance: (a) includes a comprehensive assessment; and (b) is the first or only time in a single course of treatment that a comprehensive assessment is provided	159.35
6052	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist’s specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner, if the attendance is a patient assessment: (a) before or after a comprehensive assessment under item 6051 in a single course of treatment; or (b) that follows an initial assessment under item 6057 in a single course of treatment; or (c) that follows a review under item 6058 in a single course of treatment	79.75
6057	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist’s specialty of at least 45 minutes for an initial assessment of a patient with at least 2 morbidities, following referral of the patient to the sexual health medicine specialist by a referring practitioner, if: (a) an assessment is undertaken that covers: (i) a comprehensive history, including psychosocial history and medication review; and (ii) a comprehensive multi or detailed single organ system assessment; and (iii) the formulation of differential diagnoses; and (b) a sexual health medicine specialist treatment and management plan of significant complexity that includes the following is prepared and provided to the referring practitioner: (i) an opinion on diagnosis and risk assessment; (ii) treatment options and decisions; (iii) medication recommendations; and (c) an attendance on the patient to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and (d) neither this item nor item 132 has applied to an attendance on the patient in the preceding 12 months by the same sexual health medicine specialist	278.75
6058	Professional attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist’s specialty of at least 20 minutes, after the initial attendance in a single course of treatment for a review of a patient with at least 2 morbidities if:	139.55

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Part 2 Attendances

Division 2.28 Group A32: Sexual health medicine

Clause 2.28.3

<b>Group A32—Sexual health medicine</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(a) a review is undertaken that covers: <ul style="list-style-type: none"><li>(i) review of initial presenting problems and results of diagnostic investigations; and</li><li>(ii) review of responses to treatment and medication plans initiated at time of initial consultation; and</li><li>(iii) comprehensive multi or detailed single organ system assessment; and</li><li>(iv) review of original and differential diagnoses; and</li></ul>	
	(b) the modified sexual health medicine specialist treatment and management plan is provided to the referring practitioner, which involves, if appropriate: <ul style="list-style-type: none"><li>(i) a revised opinion on diagnosis and risk assessment; and</li><li>(ii) treatment options and decisions; and</li><li>(iii) revised medication recommendations; and</li></ul>	
	(c) an attendance on the patient, being an attendance to which item 104, 105, 110, 116, 119, 132, 133, 6051 or 6052 applies did not take place on the same day by the same sexual health medicine specialist; and	
	(d) item 6057 applied to an attendance claimed in the preceding 12 months; and	
	(e) the attendance under this item is claimed by the same sexual health medicine specialist who claimed item 6057 or by a locum tenens; and	
	(f) this item has not applied more than twice in any 12 month period	
<b>Subgroup 2—Home visits</b>		
6062	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner—initial attendance in a single course of treatment	193.35
6063	Professional attendance at a place other than consulting rooms or a hospital by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty following referral of the patient to the sexual health medicine specialist by a referring practitioner—an attendance after the attendance under item 6062 in a single course of treatment	116.95
<b>Subgroup 3—Sexual health medicine case conferences</b>		
6064	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of less than 15 minutes, with the multidisciplinary case conference team	45.10
6065	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a	79.75

<b>Group A32—Sexual health medicine</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	
6067	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	119.65
6068	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to organise and coordinate a community case conference of at least 45 minutes, with the multidisciplinary case conference team	159.35
6071	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of less than 15 minutes, with the multidisciplinary case conference team	36.05
6072	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 15 minutes but less than 30 minutes, with the multidisciplinary case conference team	63.80
6074	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 30 minutes but less than 45 minutes, with the multidisciplinary case conference team	95.70
6075	Attendance by a sexual health medicine specialist in the practice of the sexual health medicine specialist's specialty, as a member of a multidisciplinary case conference team of at least 2 other formal care providers of different disciplines, to participate in a community case conference (other than to organise and coordinate the conference) of at least 45 minutes, with the multidisciplinary case conference team	127.50

Clause 2.29.1

**Division 2.29—Group A9: Contact lenses**

**2.29.1 Restrictions on item 10809**

Item 10809 does not apply if the patient’s requirement for contact lenses is only for any of the following reasons:

- (a) because the patient does not want to wear spectacles for reasons of appearance;
- (b) because the patient wants contact lenses for work or sporting purposes;
- (c) because the patient has difficulty in using, or cannot use, spectacles for psychological reasons.

**2.29.2 Items in Group A9**

This clause sets out items in Group A9.

Note: The fees in Group A9 are indexed in accordance with clause 1.3.1.

<b>Group A9—Contact lenses</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
10801	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with myopia of 5.0 dioptres or greater (spherical equivalent) in one eye	128.50
10802	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in one eye	128.50
10803	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with astigmatism of 3.0 dioptres or greater in one eye	128.50
10804	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3 logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens	128.50
10805	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with anisometropia of 3.0 dioptres or greater	128.50

<b>Group A9—Contact lenses</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(difference between spherical equivalents)	
10806	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes and for whom a contact lens is prescribed as part of a telescopic system	128.50
10807	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by pathological mydriasis, aniridia, coloboma of the iris, pupillary malformation or distortion, significant ocular deformity or corneal opacity—whether congenital, traumatic or surgical in origin	128.50
10808	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient who, because of physical deformity, are unable to wear spectacles	128.50
10809	Attendance for the investigation and evaluation of a patient for the fitting of contact lenses, with keratometry and testing with trial lenses and the issue of a prescription—one service in any period of 36 months—patient with a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction, if the condition is specified on the patient's account	128.50
10816	Attendance for the refitting of contact lenses with keratometry and testing with trial lenses and the issue of a prescription, if the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months after the fitting of a contact lens to which items 10801 to 10809 apply	128.50

## **Division 2.30—Group A35: Non-referred attendance at a residential aged care facility**

### **2.30.1 Fee in relation to the first patient during each attendance at a residential aged care facility**

- (1) For the first patient attended during one attendance by a general practitioner at one residential aged care facility on one occasion, the fee for the medical service

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Clause 2.30.2

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described in whichever of items 90020, 90035, 90043, 90051 or 90054 applies is the amount listed in the item plus \$62.65.

- (2) For the first patient attended during one attendance by a medical practitioner at one residential aged care facility on one occasion, the fee for the medical service described in whichever of items 90092, 90093, 90095, 90096, 90098, 90183, 90188, 90202, 90212 or 90215 applies is the amount listed in the item plus \$45.50.

**2.30.2 Items in Group A35**

This clause sets out items in Group A35.

Note: The fees in Group A35 (other than the fees for items 90092, 90093, 90095, 90096 and 90098) are indexed in accordance with clause 1.3.1.

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<b>Group A35—Non-referred attendance at a residential aged care facility</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
90020	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, by a general practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	17.90
90035	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 6 minutes and less than 20 minutes and including any of the following that are clinically relevant: (a) taking a patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	39.10
90043	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 20 minutes and including any of the following that are clinically relevant: (a) taking a detailed patient history; (b) performing a clinical examination;	75.75

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	(c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	
90051	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 40 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	111.50
90054	Professional attendance by a general practitioner, on care recipients in a residential aged care facility, other than a service to which another item applies, lasting at least 60 minutes and including any of the following that are clinically relevant: (a) taking an extensive patient history; (b) performing a clinical examination; (c) arranging any necessary investigation; (d) implementing a management plan; (e) providing appropriate preventive health care; for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1)	191.20
90092	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting not more than 5 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	8.50
90093	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained	16.00

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## Clause 2.30.2

	unit, lasting more than 5 minutes, but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	
90095	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 25 minutes, but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	35.50
90096	Professional attendance (other than a service to which any other item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes, but less than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion—each patient (subject to clause 2.30.1), by a medical practitioner who is not a general practitioner	57.50
90098	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a medical practitioner who is not a general practitioner—each patient (subject to subclause 2.30.1(2))	88.20
90183	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting not more than 5 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	15.15
90188	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 5 minutes but not more than 25 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	33.10
90202	Professional attendance (other than a service to which another item	64.10

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	applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 25 minutes but not more than 45 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	
90212	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 45 minutes but not more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	94.40
90215	Professional attendance (other than a service to which another item applies) at a residential aged care facility (other than a professional attendance at a self-contained unit) or professional attendance at consulting rooms situated within such a complex, if the patient is a care recipient in the facility who is not a resident of a self-contained unit, lasting more than 60 minutes—an attendance on one or more patients at one residential aged care facility on one occasion by a prescribed medical practitioner in an eligible area—each patient (subject to subclause 2.30.1(2))	152.95

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## Division 2.31—Group A36: Eating disorder services

### 2.31.1 Application of items in Group A36

#### *Eligible patients*

- (1) Subject to this clause, the items in Group A36 apply to a service provided to a patient (an **eligible patient**) covered by clause 2.31.2.

#### *Preparation of eating disorder treatment and management plans*

- (2) The items in Subgroup 1 apply to a service provided to an eligible patient by a medical practitioner (other than a specialist or consultant physician) only if:
  - (a) the service includes the preparation of a plan for the patient in accordance with clause 2.31.3; and
  - (b) during the attendance, a copy of the plan and suitable education about the patient's eating disorder is given to the patient and, if authorised by the patient, the patient's carer.
- (3) The items in Subgroup 2 apply to a service provided to an eligible patient by a consultant physician only if:
  - (a) the service includes the preparation of a plan for the patient in accordance with the requirements in clause 2.31.3; and

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Clause 2.31.1

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- (b) for a service provided by a consultant psychiatrist—during the attendance, the consultant uses an outcome tool (if clinically appropriate) and carries out a mental state examination; and
- (c) for a service provided by a consultant paediatrician—during the attendance, the consultant undertakes an assessment of the patient that includes:
  - (i) a comprehensive history (including a psychosocial history and medication review); and
  - (ii) a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and
- (d) within 2 weeks of the attendance, a copy of the plan is given to:
  - (i) the referring practitioner; and
  - (ii) if clinically appropriate—the patient and, if authorised by the patient, the patient’s carer.

*Review of eating disorder treatment and management plans*

- (4) The items in Subgroup 3 apply to a service provided to an eligible patient by a medical practitioner (other than a specialist or consultant physician) only if:
  - (a) the service includes a review of an eating disorder treatment and management plan in accordance with clause 2.31.4; and
  - (b) during the attendance, a copy of the plan and suitable education about the patient’s eating disorder is given to the patient and, if authorised by the patient, the patient’s carer.
- (5) The items in Subgroup 3 apply to a service provided to an eligible patient by a consultant physician only if:
  - (a) the service includes a review of an eating disorder treatment and management plan in accordance with clause 2.31.4; and
  - (b) for a service provided by a consultant psychiatrist—during the attendance, the consultant uses an outcome tool (if clinically appropriate) and carries out a mental state examination; and
  - (c) for a service provided by a consultant paediatrician—during the attendance, the consultant undertakes an assessment of the patient that includes:
    - (i) a comprehensive history (including a psychosocial history and medication review); and
    - (ii) a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and
  - (d) within 2 weeks of the attendance, a copy of the plan is given to:
    - (i) the referring practitioner; and
    - (ii) if clinically appropriate—the patient and, if authorised by the patient, the patient’s carer.

*Providing treatments under eating disorder treatment and management plans*

- (6) The items in Subgroup 4 apply to a service only if the service:

- (a) is provided by a medical practitioner covered by clause 2.31.5; and
- (b) is clinically indicated by an eating disorder treatment and management plan; and
- (c) is provided using at least one mental health care management strategy covered by clause 2.31.6.

### **2.31.2 Eating disorder services—patients**

- (1) For the purposes of clause 2.31.1, a patient is covered by this clause if:
  - (a) the patient has a clinical diagnosis of anorexia nervosa; or
  - (b) both:
    - (i) the patient has a clinical diagnosis of bulimia nervosa, a binge-eating disorder or other specified feeding or eating disorder; and
    - (ii) subclause (2) applies to the patient.
- (2) This subclause applies to a patient if:
  - (a) the patient has been assessed as having an eating disorder classified as severe based on clinical screening tool results; and
  - (b) the patient's condition is characterised by:
    - (i) rapid weight loss; or
    - (ii) frequent binge eating or inappropriate compensatory behaviour, as manifested by 3 or more occurrences per week; and
  - (c) at least 2 of the following apply to the patient:
    - (i) the patient is clinically underweight, with a body weight of less than 85% of the expected weight of the patient, and the weight loss is directly attributable to the eating disorder;
    - (ii) the patient is currently at risk, or has a high risk, of medical complications due to eating disorder behaviours and symptoms;
    - (iii) serious comorbid medical or psychological conditions are significantly impacting on the patient's physical or psychological health and ability to function;
    - (iv) the patient has been admitted to a hospital for an eating disorder in the previous 12 months;
    - (v) the patient has had an inadequate treatment response to evidence based eating disorder treatment over the previous 6 months despite actively and consistently participating in the treatment.

### **2.31.3 Eating disorder services—requirements for eating disorder treatment and management plan**

For the purposes of clause 2.31.1, a plan for the treatment and management of a patient's eating disorder must:

- (a) be in writing; and
- (b) include the following:
  - (i) an opinion on the diagnosis of the patient's eating disorder;

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- (ii) treatment options and recommendations to manage the patient's condition for 12 months commencing on the day the plan is prepared;
  - (iii) an outline of the options for the referral of the patient to allied health professionals for mental health and dietetic services, and to specialists, as appropriate;
  - (iv) if the plan is prepared by a consultant psychiatrist—a comprehensive evaluation of the patient's biological, psychological and social issues, and management recommendations addressing those issues;
  - (v) if the plan is prepared by a consultant paediatrician—a comprehensive history of the patient (including a psychosocial history and medication review) and a comprehensive multi-organ system assessment or a detailed single-organ system assessment; and
- (c) be expressed to expire at the end of the period mentioned in subparagraph (b)(ii).

**2.31.4 Eating disorder services—requirements for review of eating disorder treatment and management plan**

- (1) For the purposes of clause 2.31.1, a review of an eating disorder treatment and management plan for a patient must include a review of the treatment efficacy of treatments provided under the plan, including by discussing with the patient whether the treatments are meeting the patient's needs.
- (2) In conducting the review, the reviewing practitioner must:
  - (a) if the treatment options in the plan are to be continued—modify the plan, in writing, to include the recommendation that the treatment options are to be continued; and
  - (b) if the treatment options in the plan are to be revised—modify the plan, in writing, to include the recommendation that the treatment options are to be revised and the revised treatment options.
- (3) If the review is conducted by a medical practitioner (other than a specialist or consultant physician), and the practitioner considers that it is appropriate for a consultant physician to review the plan, the practitioner must refer the patient to the consultant physician for the review of the plan.

**2.31.5 Eating disorder services—medical practitioners for providing treatments**

For the purposes of clause 2.31.1, a medical practitioner is covered by this clause if:

- (a) the practitioner's name is entered in the register maintained by the Chief Executive Medicare under section 33 of the *Human Services (Medicare) Regulations 2017*; and
- (b) the practitioner is identified in the register as a medical practitioner who can provide services to which items in Subgroup 2 of Group A20, and items 283, 285, 286 and 287, apply; and

- (c) the practitioner meets any training and skills requirements determined by the General Practice Mental Health Standards Collaboration for providing those services.

Note: Section 33 of the *Human Services (Medicare) Regulations 2017* provides for the Chief Executive Medicare to establish and maintain a register of medical practitioners who may provide focused psychological strategies under the initiative known as the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) Initiative.

### **2.31.6 Eating disorder services—mental health care management strategies for use in providing treatments**

For the purposes of clause 2.31.1, the following mental health care management strategies are covered by this clause:

- (a) family based treatment (including whole family, parent based, parent only or separated therapy);
- (b) adolescent focused therapy;
- (c) cognitive behavioural therapy;
- (d) specialist supportive clinical management;
- (e) Maudsley model of anorexia treatment in adults;
- (f) interpersonal therapy for bulimia nervosa or binge-eating disorder;
- (g) dialectical behavioural therapy for bulimia nervosa or binge-eating disorder;
- (h) focal psychodynamic therapy.

### **2.31.7 Restrictions on items in Group A36—general**

*Items do not apply to services provided to admitted patients*

- (1) An item in Group A36 does not apply to an attendance on an admitted patient.

*Limit on number of plans that can be prepared for a patient each year*

- (2) An item in Subgroup 1 or 2 of Group A36 does not apply to a service that is provided to a patient who has already been provided, in the previous 12 months, with:
  - (a) another service to which an item in Subgroup 1 or 2 of Group A36 applies;
  - or
  - (b) a service to which an item in Subgroup 21 to 24 of Group A40 applies.

*Items do not apply to services provided in association with certain other services*

- (3) An item in Subgroup 1 of Group A36 does not apply to a service performed in association with a service to which item 279, 235 to 244, 735 to 758, 2713, 92115, 92121, 92127 or 92133 applies.
- (4) Item 90261 does not apply to a service performed in association with a service to which item 110, 116, 119, 132, 133, 91824, 91825, 91826, 91834, 91835, 91836, 92422, 92423, 92431 or 92432 applies.

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- (5) An item in Subgroup 3 of Group A36 does not apply to a service performed in association with a service to which item 279, 2713, 92115, 92121, 92127 or 92133 applies.

**2.31.9 Restriction on items in Group A36—limitation on number of services providing treatments under a plan**

- (1) An item in Subgroup 4 of Group A36 does not apply to a service providing a treatment to a patient under an eating disorder treatment and management plan if:
- (a) the service is provided more than 12 months after the plan is prepared; or
  - (b) the patient has already been provided with 40 services under the plan; or
  - (c) the service is provided after the patient has already been provided with 10 services under the plan but before a recommendation by a reviewing practitioner is given that additional services should be provided under the plan; or
  - (d) the service is provided after the patient has already been provided with 20 services under the plan but before recommendations that additional services should be provided under the plan are given by each of the following:
    - (i) a medical practitioner (other than a specialist or consultant physician);
    - (ii) a consultant physician; or
  - (e) the service is provided after the patient has already been provided with 30 services under the plan but before a recommendation is given by a reviewing practitioner that additional services should be provided.
- (1A) A reference in subclause (1) to a service providing a treatment to a patient includes any service to which item 309, 311, 313, 315, 2739, 2741, 2743, 2745, 80002, 80006, 80012, 80016, 80102, 80106, 80112, 80116, 80129, 80131, 80137, 80141, 80154, 80156, 80162, 80166, 91168, 91171, 91174, 91177, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91859, 91861, 91862, 91863, 91864, 91865, 91866, or 91867 applies that is provided to another person as part of the patient's treatment.
- (2) A reviewing practitioner may recommend that additional services be provided under a plan only if:
- (a) the recommendation is made as part of a service to which an item in Subgroup 3 of Group A36 or Subgroup 25 or 26 of Group A40 applies; and
  - (b) the service is provided:
    - (i) for the purposes of paragraph (1)(c)—after the patient has been provided with 10 services under the plan; and
    - (ii) for the purposes of paragraph (1)(d)—after the patient has been provided with 20 services under the plan; and
    - (iii) for the purposes of paragraph (1)(e)—after the patient has been provided with 30 services under the plan; and
  - (c) the practitioner records the recommendation in the patient's records.
- (3) For the purposes of this clause, in counting the services providing treatments under a plan, only count the services to which any of the following apply:
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- (a) items 283, 285, 286, 287, 309, 311, 313 and 315;
- (b) items 2721, 2723, 2725, 2727, 2739, 2741, 2743 and 2745;
- (c) items in Groups M6, M7 and M16 other than item 82350;
- (d) items 90271, 90272, 90273, 90274, 90275, 90276, 90277 and 90278;
- (e) items 91166, 91167, 91168, 91169, 91170, 91171, 91172, 91173, 91174, 91175, 91176, 91177, 91181 to 91188, 91194, 91195, 91196, 91197, 91198, 91199, 91200, 91201, 91202, 91203, 91204, 91205, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 91859, 91861, 91862, 91863, 91864, 91865, 91866, 91867, 92182, 92184, 92186, 92188, 92194, 92196, 92198, 92200, 93076, 93079, 93084, 93087, 93092, 93095, 93100, 93103, 93110, 93113, 93118, 93121, 93126, 93129, 93134 and 93137.

### 2.31.10 Items in Group A36

This clause sets out items in Group A36.

Note: The fees in Group A36 are indexed in accordance with clause 1.3.1.

<b>Group A36—Eating disorders</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Preparation of eating disorder treatment and management plans: general practitioners and non-specialist medical practitioners</b>		
90250	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes	74.60
90251	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes	109.85
90252	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training	94.75
90253	Professional attendance by a general practitioner to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training	139.55
90254	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes	63.15
90255	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes	92.95
90256	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 20 minutes but less than 40 minutes, if the practitioner has successfully completed mental health skills training	80.15

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<b>Group A36—Eating disorders</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
90257	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to prepare an eating disorder treatment and management plan, lasting at least 40 minutes, if the practitioner has successfully completed mental health skills training	118.10
<b>Subgroup 2—Preparation of eating disorder treatment and management plans: consultant physicians</b>		
90260	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes	478.05
90261	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to prepare an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 45 minutes	278.75
<b>Subgroup 3—Review of eating disorder treatment and management plans</b>		
90264	Professional attendance by a general practitioner to review an eating disorder treatment and management plan	74.60
90265	Professional attendance by a medical practitioner (other than a general practitioner, specialist or consultant physician) to review an eating disorder treatment and management plan	63.15
90266	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of psychiatry to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 30 minutes	298.85
90267	Professional attendance at consulting rooms by a consultant physician in the practice of the physician's specialty of paediatrics to review an eating disorder treatment and management plan, if: (a) the patient is referred; and (b) the attendance lasts at least 20 minutes	139.55
<b>Subgroup 4—Providing treatments under eating disorder treatment and management plans</b>		
90271	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	96.50
90272	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.1.1
90273	Professional attendance at consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	138.10

<b>Group A36—Eating disorders</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
90274	Professional attendance at a place other than consulting rooms by a general practitioner to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	Amount under clause 2.1.1
90275	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	81.70
90276	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 30 minutes but less than 40 minutes	Amount under clause 2.1.1
90277	Professional attendance at consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	116.90
90278	Professional attendance at a place other than consulting rooms by a medical practitioner (other than a general practitioner, specialist or consultant physician) to provide treatment under an eating disorder treatment and management plan, lasting at least 40 minutes	Amount under clause 2.1.1

## **Division 2.32—Group A37: Cardiothoracic surgeon attendance for lead extraction**

### **2.32.1 Items in Group A37**

This clause sets out items in Group A37.

Note: The fees in Group A37 are indexed in accordance with clause 1.3.1.

<b>Group A37—Cardiothoracic surgeon attendance for lead extraction</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
90300	Professional attendance by a cardiothoracic surgeon in the practice of the surgeon's speciality, if: <ul style="list-style-type: none"> <li>(a) the service is: <ul style="list-style-type: none"> <li>(i) performed in conjunction with a service (the <i>lead extraction service</i>) to which item 38358 applies; or</li> <li>(ii) performed in conjunction with a service (the <i>leadless pacemaker extraction service</i>) to which item 38373 or 38374 applies; and</li> </ul> </li> <li>(b) the surgeon: <ul style="list-style-type: none"> <li>(i) is providing surgical backup for the provider (who is not a cardiothoracic surgeon) who is performing the lead</li> </ul> </li> </ul>	895.25

**Schedule 1** General medical services table

**Part 2** Attendances

**Division 2.32** Group A37: Cardiothoracic surgeon attendance for lead extraction

Clause 2.32.1

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extraction service or the leadless pacemaker extraction service; and

- (ii) is present for the duration of the lead extraction service or the leadless pacemaker extraction service, other than during the low risk pre and post extraction phases; and
- (iii) is able to immediately scrub in and perform a thoracotomy if major complications occur

(H)

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## **Part 3—Miscellaneous services**

### **Division 3.1—Group M12: Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner**

#### **3.1.1 Definitions for item 10997**

In item 10997:

**GP management plan** means a plan under item 721 or 732 (for coordination of a review of a GP management plan under item 721).

**multidisciplinary care plan** means a plan under item 729 or 731.

**person with a chronic disease** means a person who has a care plan under item 721, 723, 729, 731 or 732.

#### **3.1.2 Restrictions on item 10988**

- (1) Item 10988 applies to an immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner only if:
  - (a) the Aboriginal and Torres Strait Islander health practitioner is appropriately qualified and trained to provide immunisations to persons; and
  - (b) the medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the person.
- (2) If the cost of the vaccine supplied in connection with a service described in item 10988 is not subsidised by the Commonwealth or a State, the service is taken not to include the supply of that vaccine.

#### **3.1.3 Restrictions on item 10989**

Item 10989 applies to an Aboriginal and Torres Strait Islander health practitioner if:

- (a) the health practitioner is appropriately qualified and trained to treat wounds; and
  - (b) a medical practitioner under whose supervision the health practitioner provides the treatment has conducted an initial assessment of the person; and
  - (c) the health practitioner has been instructed by the medical practitioner about the treatment of the wound; and
  - (d) the medical practitioner retains responsibility for the health, safety and clinical outcomes of the person.
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**Schedule 1** General medical services table

**Part 3** Miscellaneous services

**Division 3.1** Group M12: Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner

Clause 3.1.4

**3.1.4 Items in Group M12**

This clause sets out items in Group M12.

Note: The fees in Group M12 are indexed in accordance with clause 1.3.1.

**Group M12—Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner**

<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Video conferencing consultation support service provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner</b>		
10983	Attendance by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of, and under the supervision of, a medical practitioner, to provide clinical support to a patient who: (a) is participating in a video conferencing consultation with a specialist, consultant physician or psychiatrist; and (b) is not an admitted patient	33.70
<b>Subgroup 3—Services provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner</b>		
10987	Follow-up service, to a maximum of 10 services per patient in a calendar year, provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health check if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the service is consistent with the needs identified through the health assessment	24.95
10988	Immunisation provided to a person by an Aboriginal and Torres Strait Islander health practitioner if: (a) the immunisation is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital	12.50
10989	Treatment of a person's wound (other than normal aftercare) provided by an Aboriginal and Torres Strait Islander health practitioner if: (a) the treatment is provided on behalf of, and under the supervision of, a medical practitioner; and (b) the person is not an admitted patient of a hospital	12.50
10997	Service provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic disease, to a maximum of 5 services for the person in a calendar year, if: (a) the service is provided on behalf of and under the supervision of a	12.50

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**Group M12—Services provided by a practice nurse, an Aboriginal health worker or an Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner**

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<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP management plan, team care arrangements or multidisciplinary care plan in place and the service is consistent with the plan or arrangements	

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## **Division 3.2—Group M1: Management of bulk-billed services**

### **3.2.1 Definitions**

In this Division:

*concessional beneficiary* has the same meaning as in Part VII of the *National Health Act 1953*.

*general practice support service* means a service to which an item specified in subclause 3.2.2A(2) applies.

*MyMedicare* means the registration program by that name administered by the Department.

*MyMedicare service* means a service to which an item specified in subclause 3.2.2B(2) applies that is provided:

- (a) to a person enrolled in MyMedicare; and
- (b) at the general practice at which the person is so enrolled.

*unreferred service* means a medical service provided by, or on behalf of, a medical practitioner to a patient who has not been referred to the practitioner for the service.

### **3.2.2 Application of items 10990, 10991, 10992, 75855, 75856, 75857 and 75858**

If item 10990, 10991, 10992, 75855, 75856, 75857 or 75858 applies to a medical service, the fee mentioned in that item applies in addition to the fee mentioned in another item in this Schedule that applies to the service.

### **3.2.2A Application of items 75870, 75871, 75872, 75873, 75874, 75875 and 75876**

- (1) If item 75870, 75871, 75872, 75873, 75874, 75875 or 75876 applies to a medical service, the fee mentioned in that item applies in addition to the fee mentioned in an item specified in subclause (2) that applies to the service.
- (2) For the purposes of subclause (1), items 23, 24, 36, 37, 44, 47, 53, 54, 57, 59, 60, 65, 123, 124, 151, 165, 185, 187, 189, 191, 203, 206, 301, 303, 737, 741, 745,

**Schedule 1** General medical services table

**Part 3** Miscellaneous services

**Division 3.2** Group M1: Management of bulk-billed services

Clause 3.2.2B

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763, 766, 769, 776, 788, 789, 2197, 2198, 2200, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5071, 5076, 5077, 5203, 5207, 5208, 5209, 5223, 5227, 5228, 5261, 5262, 5263, 5265, 5267, 90035, 90043, 90051, 90054, 90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215, 91800, 91803, 91806, 91891 and 91893 are specified.

**3.2.2B Application of items 75880, 75881, 75882, 75883, 75884 and 75885**

- (1) If item 75880, 75881, 75882, 75883, 75884 or 75885 applies to a medical service, the fee mentioned in that item applies in addition to the fee mentioned in an item specified in subclause (2) that applies to the service.
- (2) For the purposes of subclause (1), items 91801, 91802, 91804, 91805, 91807, 91808, 91900, 91903, 91906, 91910, 91913, 91916, 91920, 91923 and 91926 are specified.

**3.2.3 Items in Group M1**

This clause sets out items in Group M1.

Note: The fees in Group M1 are indexed in accordance with clause 1.3.1.

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**Group M1—Management of bulk-billed services**

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<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>

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**Subgroup 1—Management of general bulk-billed services**

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10990	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unREFERRED service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; other than a service associated with a service: (e) to which another item in this Group applies; or (f) that is a general practice support service; or (g) that is a MyMedicare service	7.65
10991	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unREFERRED service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and	11.60

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<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<ul style="list-style-type: none"> <li>(d) the service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> <li>(i) this item; and</li> <li>(ii) any other item in this Schedule applying to the service; and</li> </ul> </li> <li>(e) the service is provided at, or from, a practice location in a Modified Monash 2 area;</li> </ul> <p>other than a service associated with a service:</p> <ul style="list-style-type: none"> <li>(f) to which another item in this Group applies; or</li> <li>(g) that is a general practice support service; or</li> <li>(h) that is a MyMedicare service</li> </ul>	
10992	<p>A medical service to which:</p> <ul style="list-style-type: none"> <li>(a) item 585, 588, 591, 594, 599, 600, 5003, 5010, 5220 or 5260 applies; or</li> <li>(b) item 761 or 772 applies (see the <i>Health Insurance (Section 3C General Medical Services – Other Medical Practitioner Determination 2018)</i>);</li> </ul> <p>if:</p> <ul style="list-style-type: none"> <li>(c) the service is an unREFERRED service; and</li> <li>(d) the service is provided to a person who is under the age of 16 or is a concessional beneficiary; and</li> <li>(e) the person is not an admitted patient of a hospital; and</li> <li>(f) the service is not provided in consulting rooms; and</li> <li>(g) the service is provided in any of the following areas: <ul style="list-style-type: none"> <li>(i) a Modified Monash 2 area;</li> <li>(ii) a Modified Monash 3 area;</li> <li>(iii) a Modified Monash 4 area;</li> <li>(iv) a Modified Monash 5 area;</li> <li>(v) a Modified Monash 6 area;</li> <li>(vi) a Modified Monash 7 area; and</li> </ul> </li> <li>(h) the service is provided by, or on behalf of, a medical practitioner whose practice location is not in an area mentioned in paragraph (g); and</li> <li>(i) the service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> <li>(i) this item; and</li> <li>(ii) the other item mentioned in paragraph (a) or (b) applying to the service</li> </ul> </li> </ul>	11.60
75855	<p>A medical service to which an item in this Schedule (other than this item) applies, if:</p> <ul style="list-style-type: none"> <li>(a) the service is an unREFERRED service; and</li> <li>(b) the service is provided to a person who is: <ul style="list-style-type: none"> <li>(i) under the age of 16; or</li> <li>(ii) a concessional beneficiary; and</li> </ul> </li> <li>(c) the person is not an admitted patient of a hospital; and</li> <li>(d) the service is bulk-billed in relation to the fees for:</li> </ul>	12.30

Schedule 1 General medical services table

Part 3 Miscellaneous services

Division 3.2 Group M1: Management of bulk-billed services

Clause 3.2.3

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in: (i) a Modified Monash 3 area; or (ii) a Modified Monash 4 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	
75856	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 5 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	13.10
75857	A medical service to which an item in this Schedule (other than this item) applies, if: (a) the service is an unreferred service; and (b) the service is provided to a person who is: (i) under the age of 16; or (ii) a concessional beneficiary; and (c) the person is not an admitted patient of a hospital; and (d) the service is bulk-billed in relation to the fees for: (i) this item; and (ii) any other item in this Schedule applying to the service; and (e) the service is provided at, or from, a practice location in a Modified Monash 6 area; other than a service associated with a service: (f) to which another item in this Group applies; or (g) that is a general practice support service; or (h) that is a MyMedicare service	13.85
75858	A medical service to which an item in this Schedule (other than this	14.65

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>item) applies, if:</p> <p>(a) the service is an unREFERRED service; and</p> <p>(b) the service is provided to a person who is:</p> <p style="padding-left: 20px;">(i) under the age of 16; or</p> <p style="padding-left: 20px;">(ii) a concessional beneficiary; and</p> <p>(c) the person is not an admitted patient of a hospital; and</p> <p>(d) the service is bulk-billed in relation to the fees for:</p> <p style="padding-left: 20px;">(i) this item; and</p> <p style="padding-left: 20px;">(ii) any other item in this Schedule applying to the service; and</p> <p>(e) the service is provided at, or from, a practice location in a Modified Monash 7 area;</p> <p>other than a service associated with a service:</p> <p>(f) to which another item in this Group applies; or</p> <p>(g) that is a general practice support service; or</p> <p>(h) that is a MyMedicare service</p>	
<b>Subgroup 2—General support service</b>		
75870	<p>Professional attendance (the <b>attendance service</b>) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if:</p> <p>(a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for:</p> <p style="padding-left: 20px;">(i) this item; and</p> <p style="padding-left: 20px;">(ii) the general practice support service item applying to the attendance service;</p> <p>other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies</p>	24.25
75871	<p>Professional attendance (the <b>attendance service</b>) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if:</p> <p>(a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for:</p> <p style="padding-left: 20px;">(i) this item; and</p> <p style="padding-left: 20px;">(ii) the general practice support service item applying to the attendance service; and</p> <p>(d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area;</p> <p>other than an attendance service associated with a service to which</p>	36.90

Schedule 1 General medical services table

Part 3 Miscellaneous services

Division 3.2 Group M1: Management of bulk-billed services

Clause 3.2.3

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	
75872	<p>Professional attendance (the <i>attendance service</i>) if:</p> <p>(a) item 763, 766, 769, 776, 788, 789, 2198, 2200, 5023, 5028, 5043, 5049, 5063, 5067, 5076, 5077, 5223, 5227, 5228, 5261, 5263, 5265, 5267 or 5262 applies; and</p> <p>(b) the attendance service is an unREFERRED service; and</p> <p>(c) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(d) the patient is not an admitted patient of a hospital; and</p> <p>(e) the attendance service is not provided in consulting rooms; and</p> <p>(f) the attendance service is provided in any of the following areas:</p> <p>(i) a Modified Monash 2 area;</p> <p>(ii) a Modified Monash 3 area;</p> <p>(iii) a Modified Monash 4 area;</p> <p>(iv) a Modified Monash 5 area;</p> <p>(v) a Modified Monash 6 area;</p> <p>(vi) a Modified Monash 7 area; and</p> <p>(g) the attendance service is provided by, or on behalf of, a general practitioner, a medical practitioner or a prescribed medical practitioner whose practice location is not in an area mentioned in paragraph (f); and</p> <p>(h) the attendance service is bulk-billed in relation to the fees for:</p> <p>(i) this item; and</p> <p>(ii) an item mentioned in paragraph (a) that applies to the service</p>	36.90
75873	<p>Professional attendance (the <i>attendance service</i>) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if:</p> <p>(a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for:</p> <p>(i) this item; and</p> <p>(ii) the general practice support service item applying to the attendance service; and</p> <p>(d) the attendance service is provided at, or from, a practice location in:</p> <p>(i) a Modified Monash 3 area; or</p> <p>(ii) a Modified Monash 4 area;</p> <p>other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75874, 75875, 75876, 75880, 75881, 75882, 75883,</p>	39.20

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	75884 or 75885 applies	
75874	Professional attendance (the <b>attendance service</b> ) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: <p>(a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> <li>(i) this item; and</li> <li>(ii) the general practice support service item applying to the attendance service; and</li> </ul> </p> <p>(d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area;</p> other than an attendance service associated with a service which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75875, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	41.65
75875	Professional attendance (the <b>attendance service</b> ) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: <p>(a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> <li>(i) this item; and</li> <li>(ii) the general practice support service item applying to the attendance service; and</li> </ul> </p> <p>(d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area;</p> other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75876, 75880, 75881, 75882, 75883, 75884 or 75885 applies	43.95
75876	Professional attendance (the <b>attendance service</b> ) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a general practice support service is provided, if: <p>(a) the attendance service is provided to a patient who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for: <ul style="list-style-type: none"> <li>(i) this item; and</li> <li>(ii) the general practice support service item applying to the attendance service; and</li> </ul> </p> <p>(d) the attendance service is provided at, or from, a practice location</p>	46.65

Schedule 1 General medical services table

Part 3 Miscellaneous services

Division 3.2 Group M1: Management of bulk-billed services

Clause 3.2.3

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75880, 75881, 75882, 75883, 75884 or 75885 applies	
<b>Subgroup 3—Patients enrolled in MyMedicare</b>		
75880	Professional attendance (the <i>attendance service</i> ) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75881, 75882, 75883, 75884 or 75885 applies	24.25
75881	Professional attendance (the <i>attendance service</i> ) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 2 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75882, 75883, 75884 or 75885 applies	36.90
75882	Professional attendance (the <i>attendance service</i> ) by a general practitioner, a medical practitioner or a prescribed medical	39.20

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>practitioner, at which a MyMedicare service is provided, if:</p> <p>(a) the attendance service is provided to a patient:</p> <p style="padding-left: 20px;">(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and</p> <p style="padding-left: 20px;">(ii) who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for:</p> <p style="padding-left: 20px;">(i) this item; and</p> <p style="padding-left: 20px;">(ii) the MyMedicare service item applying to the attendance service; and</p> <p>(d) the attendance service is provided at, or from, a practice location in:</p> <p style="padding-left: 20px;">(i) a Modified Monash 3 area; or</p> <p style="padding-left: 20px;">(ii) a Modified Monash 4 area;</p> <p>other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75883, 75884 or 75885 applies</p>	
75883	<p>Professional attendance (the <b>attendance service</b>) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if:</p> <p>(a) the attendance service is provided to a patient:</p> <p style="padding-left: 20px;">(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and</p> <p style="padding-left: 20px;">(ii) who is under the age of 16 or who is a concessional beneficiary; and</p> <p>(b) the patient is not an admitted patient of a hospital; and</p> <p>(c) the attendance service is bulk-billed in relation to the fees for:</p> <p style="padding-left: 20px;">(i) this item; and</p> <p style="padding-left: 20px;">(ii) the MyMedicare service item applying to the attendance service; and</p> <p>(d) the attendance service is provided at, or from, a practice location in a Modified Monash 5 area;</p> <p>other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75884 or 75885 applies</p>	41.65
75884	<p>Professional attendance (the <b>attendance service</b>) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if:</p> <p>(a) the attendance service is provided to a patient:</p> <p style="padding-left: 20px;">(i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and</p> <p style="padding-left: 20px;">(ii) who is under the age of 16 or who is a concessional</p>	43.95

Schedule 1 General medical services table  
Part 3 Miscellaneous services  
Division 3.2 Group M1: Management of bulk-billed services

Clause 3.2.3

<b>Group M1—Management of bulk-billed services</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 6 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75885 applies	
75885	Professional attendance (the <b>attendance service</b> ) by a general practitioner, a medical practitioner or a prescribed medical practitioner, at which a MyMedicare service is provided, if: (a) the attendance service is provided to a patient: (i) who is enrolled in MyMedicare at the general practice through which the attendance service is provided; and (ii) who is under the age of 16 or who is a concessional beneficiary; and (b) the patient is not an admitted patient of a hospital; and (c) the attendance service is bulk-billed in relation to the fees for: (i) this item; and (ii) the MyMedicare service item applying to the attendance service; and (d) the attendance service is provided at, or from, a practice location in a Modified Monash 7 area; other than an attendance service associated with a service to which item 10990, 10991, 10992, 75855, 75856, 75857, 75858, 75870, 75871, 75872, 75873, 75874, 75875, 75876, 75880, 75881, 75882, 75883 or 75884 applies	46.65

## **Part 4—Diagnostic procedures and investigations**

### **Division 4.1—Group D1: Miscellaneous diagnostic procedures and investigations**

#### **4.1.1 Meaning of report**

In this Division:

*report* means a report prepared by a medical practitioner.

#### **4.1.2 Meaning of qualified adult sleep medicine practitioner, qualified paediatric sleep medicine practitioner and qualified sleep medicine practitioner**

(1) In this Schedule:

*qualified adult sleep medicine practitioner* means a person who meets the conditions in one of subclauses (2), (3), (4) and (5) relating to:

- (a) the field (the *relevant field*) of adult sleep medicine; or
- (b) the training program (the *relevant training program*) of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association known as the Advanced Training Program in Adult Sleep Medicine.

*qualified paediatric sleep medicine practitioner* means a person who meets the conditions in one of subclauses (2), (3), (4) and (5) relating to:

- (a) the field (the *relevant field*) of paediatric sleep medicine; or
- (b) the training program (the *relevant training program*) of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association known as the Advanced Training Program in Paediatric Sleep Medicine.

*qualified sleep medicine practitioner* means a qualified adult sleep medicine practitioner or a qualified paediatric sleep medicine practitioner.

*RACP Advisory Committee* means the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians.

*RACP Appeal Committee* means the Appeal Committee of the Royal Australasian College of Physicians.

*RACP Credentialling Subcommittee* means the Credentialling Subcommittee of the RACP Advisory Committee.

*Conditions for being a qualified sleep medicine practitioner*

(2) A person meets the conditions in this subclause if the person has been assessed by the RACP Credentialling Subcommittee or the RACP Appeal Committee as

Clause 4.1.3

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having had, before 1 March 1999, sufficient training and experience in the relevant field to be competent in:

- (a) independent clinical assessment and management of patients with respiratory sleep disorders; and
- (b) reporting sleep studies.

(3) A person meets the conditions in this subclause if:

- (a) the person has been assessed by the RACP Credentialling Subcommittee or the RACP Appeal Committee as having had, before 1 March 1999, substantial training or experience in sleep medicine, but requiring further specified training or experience in the relevant field to be competent in:
  - (i) independent clinical assessment and management of patients with respiratory sleep disorders; and
  - (ii) reporting sleep studies; and
- (b) either:
  - (i) the person has been assessed by the RACP Credentialling Subcommittee as having satisfactorily finished the further specified training or gained the further specified experience; or
  - (ii) where an assessment mentioned in paragraph (a) has been carried out, less than 2 years has passed since the assessment.

(4) A person meets the conditions in this subclause if the person has attained Level I or Level II of the relevant training program after completing at least 12 months core training, including clinical practice in the relevant field and in reporting sleep studies.

(5) A person meets the conditions in this subclause if the RACP Advisory Committee has recognised the person, in writing, as having training equivalent to the training mentioned in subclause (4).

**4.1.3 Restriction on item 11801—service provided in association with other services**

Item 11801 does not apply to a service described in the item if the service is provided in association with a service described in item 11800, 11810, 11820, 11823, 11830 or 11833.

**4.1.3A Restriction on items 11704, 11705, 11716, 11717, 11723 and 11735—reports**

- (1) Items 11704, 11705, 11716, 11717, 11723 and 11735 apply to a service only if:
  - (a) the report required for the service complies with subclause (2); and
  - (b) if the service was requested—a copy of the report is provided to the requesting practitioner.
- (2) The report must:
  - (a) be in writing; and
  - (b) be prepared by a specialist or consultant physician; and

- (c) include an interpretation of the trace, including the indicators for the investigation; and
- (d) include comments on the significance of:
  - (i) the trace findings; and
  - (ii) the relationship of the trace findings to clinical decision making for the patient in the clinical context; and
- (e) if appropriate—include a copy of the trace and any measurements taken or automatically generated; and
- (f) for item 11705—be a report of a trace from a twelve-lead electrocardiography for the patient:
  - (i) provided with the request by the requesting practitioner; and
  - (ii) that has not previously been reported on.

#### **4.1.3B Restriction on item 11714—clinical notes**

- (1) Item 11714 applies to a service only if:
  - (a) the clinical note required for the service complies with subclause (2); and
  - (b) if appropriate, a copy of the clinical note is provided to the requesting practitioner.
- (2) The clinical note must include:
  - (a) comments on the significance of:
    - (i) the trace findings; and
    - (ii) the relationship of the trace findings to clinical decision making for the patient in the clinical context; and
  - (b) an interpretation that is not based solely on measurements or diagnoses automatically generated from the trace.

#### **4.1.3C Restriction on items 11704 and 11705—financial relationship**

Items 11704 and 11705 apply to a service only if the medical practitioner providing the service does not have a financial relationship with the medical practitioner who has requested the service.

#### **4.1.3D Restrictions on items 11729, 11730 and 11732—patient limitations**

- (1) Items 11729, 11730 and 11732 apply to a service provided to a patient only if:
  - (a) the patient's body habitus, or other physical condition, is suitable for exercise stress testing or pharmacological induced stress testing; and
  - (b) the patient can complete the exercise sufficiently, or respond adequately to pharmacological induced stress, for the required measurements to be taken.
- (2) Despite subclause (1), item 11729 does not apply to a service if:
  - (a) the patient is asymptomatic and has a normal cardiac examination; or
  - (b) the service is to monitor a patient who has a known cardiac disease, but the absence of symptom evolution suggests the disease has not progressed; or

Clause 4.1.3E

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- (c) the patient has an abnormal resting electrocardiography result which would prevent the interpretation of results.
- (3) Despite subclause (1), item 11730 does not apply to a service if the patient is asymptomatic and has a normal cardiac examination.

**4.1.3E Restriction on items 11729, 11730 and 11732—safety requirements**

- (1) Items 11729, 11730 and 11732 apply to a service provided to a patient only if:
  - (a) the service is performed on premises equipped with resuscitation equipment, including a defibrillator; and
  - (b) a person trained in the matters mentioned in subclause (2) and cardiopulmonary resuscitation is in continuous personal attendance during the monitoring and recording; and
  - (c) at the time the service is performed, a second person trained in cardiopulmonary resuscitation is located at the premises and is immediately available to respond if required; and
  - (d) at least one of the persons mentioned in paragraphs (b) and (c) is a medical practitioner.
- (2) For the purposes of paragraph (1)(b), the matters are:
  - (a) how to safely perform exercise or pharmacological stress monitoring and recording; and
  - (b) how to recognise the symptoms and signs of cardiac disease.

**4.1.3F Restriction on certain items—patients receiving hospital treatment or hospital-substitute treatment**

Items 11704, 11707, 11714, 11716, 11717, 11723 and 11735 do not apply to a service provided to a patient if the patient is being provided with the service as part of an episode of:

- (a) hospital treatment; or
- (b) hospital-substitute treatment in respect of which the patient chooses to receive a benefit from a private health insurer.

**4.1.3G Restriction on certain items—other services on the same day**

- (1) Item 11704 does not apply to a service if the specialist or consultant physician providing the service provides to the patient, on the same day, another service to which another item in Part 2 (attendances) applies.
- (2) Item 11705 does not apply to a service if the specialist or consultant physician providing the service provides to the patient, on the same day, another service to which another item in Part 2 (attendances) applies, unless there has been a significant change in the patient's clinical condition or care circumstances that necessitates the providing of the service.

#### 4.1.4 Restrictions on items 12306 to 12322

- (1) Items 12306 to 12322 apply to a service for a patient only as set out in this clause.
- (2) The items apply to a service that is provided by a specialist or consultant physician to whom the patient has been referred by another medical practitioner.
- (3) The items also apply to a service that is provided as follows:
  - (a) a person (the **radiation licence holder**) who holds a radiation licence under a law of a State or Territory performs the service (other than interpretation and reporting) under the supervision of a specialist or consultant physician;
  - (b) the specialist or consultant physician performs the interpretation and reporting for the service;
  - (c) the radiation licence authorises the radiation licence holder to undertake the activities involved in performing the service (other than interpretation and reporting);
  - (d) the patient has been referred to the specialist or consultant physician by another medical practitioner;
  - (e) for items 12320 and 12322—if the service is performed using quantitative computed tomography:
    - (i) the radiation licence holder is registered as a medical radiation practitioner under a law of a State or Territory; and
    - (ii) 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.

#### 4.1.5 Items in Group D1

This clause sets out items in Group D1.

Note: The fees in Group D1 are indexed in accordance with clause 1.3.1.

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
<b>Subgroup 1—Neurology</b>		
11000	Electroencephalography, other than 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.)	128.10
11003	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	338.85

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	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	
11004	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	338.85
11005	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	338.85
11009	Electrocorticography	338.85
11012	Neuromuscular electrodiagnosis—conduction studies on one nerve or electromyography of one or more muscles using concentric needle electrodes or both these examinations (other than a service associated with a service to which item 11015 or 11018 applies)	116.55
11015	Neuromuscular electrodiagnosis—conduction studies on 2 or 3 nerves with or without electromyography (other than a service associated with a service to which item 11012 or 11018 applies)	156.00
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 (other than a service associated with a service to which item 11012 or 11015 applies)	233.05
11021	Neuromuscular electrodiagnosis—repetitive stimulation for study of neuromuscular conduction or electromyography with quantitative computerised analysis or both of these examinations	156.00
11024	Central nervous system evoked responses, investigation of, by computerised averaging techniques, other than a service involving quantitative topographic mapping of event-related potentials or involving multifocal multichannel objective perimetry—one or 2 studies	118.45
11027	Central nervous system evoked responses, investigation of, by computerised averaging techniques, other than a service involving quantitative topographic mapping of event-related potentials or	175.70

General medical services table **Schedule 1**  
Diagnostic procedures and investigations **Part 4**  
Group D1: Miscellaneous diagnostic procedures and investigations **Division 4.1**

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	involving multifocal multichannel objective perimetry—3 or more studies	
<b>Subgroup 2—Ophthalmology</b>		
11200	Provocative test or tests for open angle glaucoma, including water drinking	42.45
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 the specialist's or consultant physician's speciality	112.65
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 the specialist's or consultant physician's speciality	112.65
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	112.65
11211	Dark adaptometry of one or both eyes with a quantitative estimation of threshold in log lumens at 45 minutes of dark adaptations	112.65
11215	Retinal angiography, multiple exposures, of one eye with intravenous dye injection	127.95
11218	Retinal angiography, multiple exposures of both eyes with intravenous dye injection	158.10
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	41.60
11220	Optical coherence tomography, to a maximum of one service per eye per lifetime, for the assessment of the need for treatment following provision of pharmaceutical benefits scheme-subsidised ocriplasmin	41.60
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 the specialist's 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	70.55
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 the specialist's specialty, if indicated by the presence of	42.50

**Schedule 1** General medical services table**Part 4** Diagnostic procedures and investigations**Division 4.1** Group D1: Miscellaneous diagnostic procedures and investigations

## Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	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	
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 a report	127.70
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, other than a service associated with a service to which an item in Group II of the diagnostic imaging services table applies	84.75
11240	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of one eye before lens surgery on that eye, other than a service associated with a service to which an item in Group II of the diagnostic imaging services table applies	84.75
11241	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for bilateral eye measurement before lens surgery on both eyes, other than a service associated with a service to which an item in Group II of the diagnostic imaging services table applies	107.85
11242	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of an eye previously measured and on which lens surgery has been performed, and if further lens surgery is contemplated in that eye, other than a service associated with a service to which an item in Group II of the diagnostic imaging services table applies	83.35
11243	Orbital contents, unidimensional ultrasonic echography or partial coherence interferometry of, for the measurement of a second eye if: (a) surgery for the first eye has resulted in more than one dioptre of error; or (b) more than 3 years have elapsed since the surgery for the first eye; other than a service associated with a service to which an item in Group II of the diagnostic imaging services table applies	83.35
11244	Orbital contents, diagnostic B-scan of, by a specialist practising in the specialist's specialty of ophthalmology, not being a service associated with a service to which an item in Group II of the diagnostic imaging services table applies	80.10
<b>Subgroup 3—Otolaryngology</b>		
11300	Brain stem evoked response audiometry, if: (a) the service is not for the purposes of programming either an auditory	200.30

General medical services table **Schedule 1**  
Diagnostic procedures and investigations **Part 4**  
Group D1: Miscellaneous diagnostic procedures and investigations **Division 4.1**

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	implant or the sound processor of an auditory implant; and (b) a service to which item 82300 applies has not been performed on the patient on the same day (Anaes.)	
11302	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 Applicable up to a total of 4 services to which this item, item 11342 or item 11345 applies on the same day	203.50
11303	Electrocochleography, extratympanic method, one or both ears	200.30
11304	Electrocochleography, transtympanic membrane insertion technique, one or both ears	329.80
11306	Non-determinate audiometry, if a service to which item 82306 applies has not been performed on the patient on the same day	22.80
11309	Audiogram, air conduction, if a service to which item 82309 applies has not been performed on the patient on the same day	27.35
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	38.65
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	51.20
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	63.20
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	21.00
11332	Oto-acoustic emission audiometry for the detection of outer hair cell functioning in the cochlea, 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	60.95
11340	Investigation of the vestibular function to assist in the diagnosis,	196.80

**Schedule 1** General medical services table

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**Division 4.1** Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

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**Group D1—Miscellaneous diagnostic procedures and investigations**

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<b>Column 1</b> <b>Item</b>	<b>Column 2</b> <b>Description</b>	<b>Column 3</b> <b>Fee (\$)</b>
	treatment or management of a vestibular or related disorder, performed by or on behalf of a medical practitioner: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular-motor function; and (b) using up to 2 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027 or 11205 applies	
11341	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: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular-motor function; and (b) using 3 or 4 clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027 or 11205 applies	394.50
11343	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: (a) to assess one or more of the following: (i) the organs of the peripheral vestibular system (utricle, saccule, lateral, superior and posterior semicircular canals, and vestibular nerve); (ii) muscular or eye movement responses elicited by vestibular stimulation; (iii) static signs of vestibular dysfunction; (iv) the central ocular-motor function; and (b) using 5 or more clinically recognised tests; other than a service associated with a service to which item 11015, 11021, 11024, 11027 or 11205 applies	590.25
<b>Subgroup 4—Respiratory</b>		
11503	Complex measurement of properties of the respiratory system, including the lungs and respiratory muscles, that is performed:	144.25

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<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>(i) measurement of absolute lung volumes by any method;</p> <p>(ii) measurement of carbon monoxide diffusing capacity by any method;</p> <p>(iii) measurement of airway or pulmonary resistance by any method;</p> <p>(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>(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> <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 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>	
11505	<p>Measurement of spirometry, that:</p> <p>(a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and</p>	42.80

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**Part 4** Diagnostic procedures and investigations

**Division 4.1** Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>(b) is performed to confirm diagnosis of:</p> <ul style="list-style-type: none"> <li>(i) asthma; or</li> <li>(ii) chronic obstructive pulmonary disease (COPD); or</li> <li>(iii) another cause of airflow limitation;</li> </ul> <p>each occasion at which 3 or more recordings are made</p> <p>Applicable only once in any 12 month period</p>	
11506	<p>Measurement of spirometry, that:</p> <ul style="list-style-type: none"> <li>(a) involves a permanently recorded tracing, performed before and after inhalation of a bronchodilator; and</li> <li>(b) is performed to: <ul style="list-style-type: none"> <li>(i) confirm diagnosis of chronic obstructive pulmonary disease (COPD); or</li> <li>(ii) assess acute exacerbations of asthma; or</li> <li>(iii) monitor asthma and COPD; or</li> <li>(iv) assess other causes of obstructive lung disease or the presence of restrictive lung disease;</li> </ul> </li> </ul> <p>each occasion at which recordings are made</p>	21.40
11507	<p>Measurement of spirometry:</p> <ul style="list-style-type: none"> <li>(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</li> <li>(b) fractional exhaled nitric oxide (FeNO) concentration in exhaled breath;</li> </ul> <p>if:</p> <ul style="list-style-type: none"> <li>(c) the measurement is performed: <ul style="list-style-type: none"> <li>(i) under the supervision of a specialist or consultant physician; and</li> <li>(ii) with continuous attendance by a respiratory scientist; and</li> <li>(iii) in a respiratory laboratory equipped to perform complex lung function tests; and</li> </ul> </li> <li>(d) a permanently recorded tracing and written report is provided; and</li> <li>(e) 3 or more spirometry recordings are performed unless difficult to achieve for clinical reasons;</li> </ul> <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>	104.30
11508	<p>Maximal symptom-limited incremental exercise test using a calibrated cycle ergometer or treadmill, if:</p> <ul style="list-style-type: none"> <li>(a) the test is performed for the evaluation of: <ul style="list-style-type: none"> <li>(i) breathlessness of uncertain cause from tests performed at rest; or</li> <li>(ii) breathlessness out of proportion with impairment due to</li> </ul> </li> </ul>	302.60

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>known conditions; or</p> <p>(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>(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> <p>(d) the test is performed in a respiratory laboratory equipped with airway management and defibrillator equipment; and</p> <p>(e) there is continuous measurement of at least the following:</p> <p style="padding-left: 20px;">(i) work rate;</p> <p style="padding-left: 20px;">(ii) pulse oximetry;</p> <p style="padding-left: 20px;">(iii) respired oxygen and carbon dioxide partial pressures and respired volumes;</p> <p style="padding-left: 20px;">(iv) ECG;</p> <p style="padding-left: 20px;">(v) heart rate and blood pressure; and</p> <p>(f) interpretation and preparation of a permanent report is provided by a specialist or consultant physician who is also responsible for the supervision of technical staff and quality assurance</p>	
11512	<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) that is performed with a respiratory scientist in continuous attendance; and</p> <p>(c) that is performed in a respiratory laboratory equipped to perform complex lung function tests; and</p> <p>(d) that is performed under the supervision of a specialist or consultant physician who is responsible for staff training, supervision, quality assurance and the issuing of written reports; and</p> <p>(e) for which a permanently recorded tracing and written report is provided; and</p> <p>(f) for which 3 or more spirometry recordings are performed; each occasion at which one or more such tests are performed</p> <p>Not applicable for a service associated with a service to which item 11503 or 11507 applies</p>	64.25
<b>Subgroup 5—Vascular</b>		
11600	Central venous, pulmonary arterial, systemic arterial or cardiac	72.10

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Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	intracavity blood pressure monitoring by indwelling catheter—once per day for each type of pressure for a patient, other than a service: (a) associated with the management of general anaesthesia; and (b) to which item 13876 applies	
11602	Investigation of venous reflux or obstruction in one or more limbs at rest by CW Doppler or pulsed Doppler involving examination at multiple sites along each limb using intermittent limb compression or 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	60.10
11604	Investigation of chronic venous disease in the upper and lower extremities, one or more limbs, by plethysmography (excluding photoplethysmography)—examination, hard copy trace and written report, not being a service associated with a service to which item 32500 applies	78.75
11605	Investigation of complex chronic lower limb reflux or obstruction, in one or more limbs, by infrared photoplethysmography, during and following exercise to determine surgical intervention or the conservative management of deep venous thrombotic disease—hard copy trace, calculation of 90% recovery time and written report, not being a service associated with a service to which item 32500 applies	78.75
11607	Continuous ambulatory blood pressure recording for 24 hours or more for a patient if: (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: (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: (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: (A) 177;	107.20

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Group D1: Miscellaneous diagnostic procedures and investigations **Division 4.1**

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(B) 224 to 228; (C) 229 to 244; (D) 699; (E) 701 to 707; (F) 715; (G) 721 to 732; (H) 735 to 758.	
	Applicable only once in any 12 month period	
	Note: Items 177 and 699 are specified in determinations made under subsection 3C(1) of the Act.	
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	66.30
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	66.30
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, if the exercise workload is quantifiably documented—examination and report	116.95
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	78.75
11615	Measurement of digital temperature, one 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	78.95
11627	Pulmonary artery pressure monitoring during open heart surgery, in a patient under 12 years of age	237.90
<b>Subgroup 6—Cardiovascular</b>		
11704	Twelve-lead electrocardiography, trace and formal report, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and	32.55

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Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies	
11705	Twelve-lead electrocardiography, formal report only, by a specialist or a consultant physician, if the service: (a) is requested by a requesting practitioner; and (b) is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	19.15
11707	Twelve-lead electrocardiography, trace only, by a medical practitioner, if: (a) the trace: (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 (b) the service is not associated with a service to which item 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies Applicable not more than twice on the same day	19.15
11713	Signal averaged ECG recording involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician	72.55
11714	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 Applicable not more than twice on the same day	25.20
11716	Continuous ambulatory electrocardiogram recording for 12 or more hours, by a specialist or consultant physician, if the service: (a) is indicated for the evaluation of any of the following: (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 (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 (c) includes interpretation and report; and	174.30

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<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<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>	
11717	<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> <p style="padding-left: 20px;">(i) is connected continuously to the patient for between 7 and 30 days; and</p> <p style="padding-left: 20px;">(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 reporting (including the indication for the investigation); and</p> <p>(c) is for the investigation of recurrent episodes of:</p> <p style="padding-left: 20px;">(i) unexplained syncope; or</p> <p style="padding-left: 20px;">(ii) palpitation; or</p> <p style="padding-left: 20px;">(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, 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>	102.40
11719	<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> <p>Applicable once in any 12 month period</p>	69.50
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>	69.50
11721	<p>Implanted pacemaker testing of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, other than a service associated with a service to which item 11704, 11719, 11720, 11725 or 11726 applies</p>	72.55
11723	<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: 20px;">(i) is connected continuously to the patient for up to 7 days; and</p>	54.05

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<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>(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>(i) unexplained syncope; or</p> <p>(ii) palpitation; or</p> <p>(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>	
11724	Upright 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	175.70
11725	Implanted defibrillator (including cardiac resynchronisation defibrillator) remote monitoring involving reviews (without patient attendance) of arrhythmias, lead and device parameters, if at least 2 remote reviews are provided in a 12 month period Applicable once in any 12 month period	197.20
11726	Implanted defibrillator testing, with patient attendance, following detection of abnormality by remote monitoring involving electrocardiography, measurement of rate, width and amplitude of stimulus, not being a service associated with a service to which item 11727 applies	98.60
11727	Implanted defibrillator testing involving electrocardiography, assessment of pacing and sensing thresholds for pacing and defibrillation electrodes, download and interpretation of stored events and electrograms, including programming when required, other than a service associated with a service to which item 11719, 11720, 11721, 11725 or 11726 applies	98.60
11728	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 For any particular patient—applicable not more than 4 times in any 12 months	36.15
11729	Multi channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, if:	158.35

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**Group D1—Miscellaneous diagnostic procedures and investigations**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	<ul style="list-style-type: none"> <li>(a) the patient is 17 years or more; and</li> <li>(b) the patient: <ul style="list-style-type: none"> <li>(i) has symptoms consistent with cardiac ischemia; or</li> <li>(ii) has other cardiac disease which may be exacerbated by exercise; or</li> <li>(iii) has a first degree relative with suspected heritable arrhythmia; and</li> </ul> </li> <li>(c) the monitoring and recording: <ul style="list-style-type: none"> <li>(i) is not less than 20 minutes; and</li> <li>(ii) includes resting electrocardiogram; and</li> </ul> </li> <li>(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</li> <li>(e) the service is not a service: <ul style="list-style-type: none"> <li>(i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or</li> <li>(ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies</li> </ul> </li> </ul>	
	Applicable only once in any 24 month period	
11730	<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"> <li>(a) the patient is less than 17 years; and</li> <li>(b) the patient: <ul style="list-style-type: none"> <li>(i) has symptoms consistent with cardiac ischemia; or</li> <li>(ii) has other cardiac disease which may be exacerbated by exercise; or</li> <li>(iii) has a first degree relative with suspected heritable arrhythmia; and</li> </ul> </li> <li>(c) the monitoring and recording: <ul style="list-style-type: none"> <li>(i) is not less than 20 minutes in duration; and</li> <li>(ii) includes resting electrocardiogram; and</li> </ul> </li> <li>(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</li> <li>(e) the service is not a service: <ul style="list-style-type: none"> <li>(i) provided on the same occasion as a service to which item 11704, 11705, 11707 or 11714 applies; or</li> <li>(ii) performed within 24 months of a service to which item 55141, 55143, 55145, 55146, 61324, 61329, 61345, 61349, 61357, 61394, 61398, 61406, 61410 or 61414 applies</li> </ul> </li> </ul>	158.35
	Applicable only once in any 24 month period	

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Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
11731	Implanted electrocardiogram loop recording, by a medical practitioner, including reprogramming (if required), retrieval of stored data, analysis, interpretation and report, 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	36.15
11732	Multi-channel electrocardiogram monitoring and recording during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts), performed by a cardiologist with relevant expertise in genetic heart disease, if: (a) the patient is: (i) under investigation or treatment for long QT syndrome, catecholaminergic polymorphic ventricular tachycardia or arrhythmogenic cardiomyopathy; or (ii) a first degree relative of a person with confirmed long QT syndrome, catecholaminergic polymorphic ventricular tachycardia, arrhythmogenic cardiomyopathy or unexplained sudden cardiac death at 40 years of age or younger; and (b) the monitoring and recording: (i) is for at least 20 minutes; and (ii) includes resting electrocardiogram; and (c) the cardiologist produces a report that includes interpretation of the monitoring and recording data (commenting on the significance of the data) and discussion of the relationship of the data to clinical decision making for the patient in the clinical context; and (d) the service is not provided on the same occasion as a service to which item 11704, 11705, 11707, 11714, 11729 or 11730 applies Applicable once per day	167.55
11735	Continuous ambulatory electrocardiogram recording for 7 days, by a specialist or consultant physician, if the service: (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 (b) is for the investigation of: (i) episodes of suspected intermittent cardiac arrhythmia or episodes of syncope; or (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 (c) includes interpretation and report; and	133.10

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Group D1: Miscellaneous diagnostic procedures and investigations **Division 4.1**

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(d) is not a service: <ul style="list-style-type: none"> <li>(i) provided in association with ambulatory blood pressure monitoring; or</li> <li>(ii) associated with a service to which item 11716, 11717, 11723, 12203, 12204, 12205, 12207, 12208, 12210, 12213, 12215, 12217 or 12250 applies</li> </ul> <p>Applicable not more than 4 times in any 12 month period</p>	
11736	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: <ul style="list-style-type: none"> <li>(a) is provided to a patient who has been diagnosed as having had an embolic stroke of undetermined source; and</li> <li>(b) is not a service to which item 38288 applies</li> </ul> <p>Applicable not more than 4 times in any 12 month period</p>	36.75
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: <ul style="list-style-type: none"> <li>(a) an investigation for a patient with: <ul style="list-style-type: none"> <li>(i) cryptogenic stroke; or</li> <li>(ii) recurrent unexplained syncope; and</li> </ul> </li> <li>(b) not a service to which item 38285 applies</li> </ul> <p>Applicable only once in any 4 week period</p>	36.75
<b>Subgroup 7—Gastroenterology and colorectal</b>		
11800	Oesophageal motility test, manometric	181.50
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: <ul style="list-style-type: none"> <li>(a) a catheter-based ambulatory oesophageal pH monitoring: <ul style="list-style-type: none"> <li>(i) has been attempted on the patient but failed due to clinical complications; or</li> <li>(ii) is not clinically appropriate for the patient due to anatomical reasons (nasopharyngeal anatomy) preventing the use of catheter-based pH monitoring; and</li> </ul> </li> <li>(b) 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 (Anaes.)</li> </ul>	273.65
11810	Clinical assessment of gastro-oesophageal reflux disease involving 24-hour pH monitoring, including analysis, interpretation and report and including any associated consultation	181.50
11820	Capsule endoscopy to investigate an episode of obscure gastrointestinal	1,279.15

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	bleeding, using a capsule endoscopy device (including administration of the capsule, associated endoscopy procedure if required for placement, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is provided to a patient who: (i) has overt gastrointestinal bleeding; or (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 (b) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (c) the service has not been provided to the same patient on more than 2 occasions in the preceding 12 months; and (d) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (e) the service is not associated with a service to which item 30680, 30682, 30684 or 30686 applies	
11823	Capsule endoscopy to conduct small bowel surveillance of a patient diagnosed with Peutz-Jeghers Syndrome, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the item is performed only once in any 2 year period; and (c) the service is not associated with balloon enteroscopy	1,279.15
11830	Diagnosis of abnormalities of the pelvic floor involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex	194.40
11833	Diagnosis of abnormalities of the pelvic floor and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency	259.85
<b>Subgroup 8—Genito-urinary physiological investigations</b>		
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	28.65
11912	Cystometrography: (a) with measurement of any one or more of the following: (i) urine flow rate;	205.50

General medical services table **Schedule 1**  
Diagnostic procedures and investigations **Part 4**  
Group D1: Miscellaneous diagnostic procedures and investigations **Division 4.1**

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(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.)	
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.)	445.75
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 item 60506 or 60509 applies, other than a service associated with a service to which any of items 11012 to 11027, 11900 to 11917 and 36800 applies (Anaes.)	445.75
<b>Subgroup 9—Allergy testing</b>		
12000	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	40.50
12001	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 Applicable only once in any 12 month period	40.50
12002	Repeat skin prick testing of a patient for aeroallergens, including all allergens tested on the same day, if: (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 (b) the service is not associated with a service to which item 12000,	40.50

**Schedule 1** General medical services table**Part 4** Diagnostic procedures and investigations**Division 4.1** Group D1: Miscellaneous diagnostic procedures and investigations

## Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	12001, 12005, 12012, 12017, 12021, 12022 or 12024 applies Applicable only once in any 12 month period	
12003	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	40.50
12004	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	61.25
12005	Skin testing: (a) performed by or on behalf of a specialist or consultant physician in the practice of the specialist's or consultant physician's specialty; and (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 (c) including all allergens tested on the same day; and (d) not being a service associated with a service to which item 12000, 12001, 12002, 12003, 12012, 12017, 12021, 12022 or 12024 applies	82.40
12012	Epicutaneous patch testing in the investigation of allergic dermatitis using not more than 25 allergens	21.65
12017	Epicutaneous patch testing in the investigation of allergic dermatitis using more than 25 allergens but not more than 50 allergens	73.10
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 the specialist's or consultant physician's specialty, using more than 50 allergens but not more than 75 allergens	120.15
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 the specialist's or consultant physician's specialty, using more than 75 allergens but not more than 100 allergens	141.10
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 the specialist's or consultant physician's specialty, using more than 100 allergens	160.75
<b>Subgroup 10—Other diagnostic procedures and investigations</b>		
12200	Collection of specimen of sweat by iontophoresis	38.70
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	2,489.85

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	arranging services to which items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient if: <ul style="list-style-type: none"> <li>(a) the patient has had a total thyroidectomy and one ablative dose of radioactive iodine; and</li> <li>(b) the patient is maintained on thyroid hormone therapy; and</li> <li>(c) the patient is at risk of recurrence; and</li> <li>(d) on at least one 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</li> <li>(e) either: <ul style="list-style-type: none"> <li>(i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or</li> <li>(ii) withdrawal is medically contra-indicated because the patient has: <ul style="list-style-type: none"> <li>(A) unstable coronary artery disease; or</li> <li>(B) hypopituitarism; or</li> <li>(C) a high risk of relapse or exacerbation of a previous severe psychiatric illness</li> </ul> </li> </ul> </li> </ul>	
	Applicable once only in a 12 month period	
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: <ul style="list-style-type: none"> <li>(a) either: <ul style="list-style-type: none"> <li>(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 clinical screening tool results; or</li> <li>(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</li> </ul> </li> <li>(b) the overnight diagnostic assessment is performed to investigate: <ul style="list-style-type: none"> <li>(i) suspected obstructive sleep apnoea syndrome where the patient is assessed as not suitable for an unattended sleep study; or</li> <li>(ii) suspected central sleep apnoea syndrome; or</li> <li>(iii) suspected sleep hypoventilation syndrome; or</li> <li>(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</li> <li>(v) unexplained hypersomnolence which is not attributed to inadequate sleep hygiene or environmental factors; or</li> </ul> </li> </ul>	611.80

**Schedule 1** General medical services table

**Part 4** Diagnostic procedures and investigations

**Division 4.1** Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	<ul style="list-style-type: none"> <li>(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</li> <li>(vii) suspected sleep related movement disorder, where the diagnosis of restless legs syndrome is not evident on clinical assessment; and</li> <li>(c) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</li> <li>(d) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:               <ul style="list-style-type: none"> <li>(i) airflow;</li> <li>(ii) continuous EMG;</li> <li>(iii) anterior tibial EMG;</li> <li>(iv) continuous ECG;</li> <li>(v) continuous EEG;</li> <li>(vi) EOG;</li> <li>(vii) oxygen saturation;</li> <li>(viii) respiratory movement (chest and abdomen);</li> <li>(ix) position; and</li> </ul> </li> <li>(e) polygraphic records are:               <ul style="list-style-type: none"> <li>(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</li> <li>(ii) stored for interpretation and preparation of a report; and</li> </ul> </li> <li>(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</li> <li>(g) the overnight diagnostic assessment is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</li> </ul>	
	Applicable only once in any 12 month period	
12204	Overnight assessment of positive airway pressure, for at least 8 hours, for a patient aged 18 years or more, if: <ul style="list-style-type: none"> <li>(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</li> <li>(b) the patient has not undergone positive airway pressure therapy in the previous 6 months; and</li> <li>(c) following professional attendance on the patient by a qualified adult sleep medicine practitioner or a consultant respiratory physician</li> </ul>	611.80

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**Group D1—Miscellaneous diagnostic procedures and investigations**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	<p>(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"> <li>(i) airflow;</li> <li>(ii) continuous EMG;</li> <li>(iii) anterior tibial EMG;</li> <li>(iv) continuous ECG;</li> <li>(v) continuous EEG;</li> <li>(vi) EOG;</li> <li>(vii) oxygen saturation;</li> <li>(viii) respiratory movement;</li> <li>(ix) position; and</li> </ul> <p>(f) polygraphic records are:</p> <ul style="list-style-type: none"> <li>(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</li> <li>(ii) stored for interpretation and preparation of a report; and</li> </ul> <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 described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</p>	
	<i>Applicable only once in any 12 month period</i>	
12205	<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, if:</p> <p>(a) any of the following subparagraphs applies:</p> <ul style="list-style-type: none"> <li>(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;</li> <li>(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;</li> </ul>	611.80

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<ul style="list-style-type: none"> <li>(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</li> <li>(b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</li> <li>(c) there is continuous monitoring and recording, performed in accordance with current professional guidelines, of the following measures:               <ul style="list-style-type: none"> <li>(i) airflow;</li> <li>(ii) continuous EMG;</li> <li>(iii) anterior tibial EMG;</li> <li>(iv) continuous ECG;</li> <li>(v) continuous EEG;</li> <li>(vi) EOG;</li> <li>(vii) oxygen saturation;</li> <li>(viii) respiratory movement (chest and abdomen);</li> <li>(ix) position; and</li> </ul> </li> <li>(d) polygraphic records are:               <ul style="list-style-type: none"> <li>(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</li> <li>(ii) stored for interpretation and preparation of a report; and</li> </ul> </li> <li>(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</li> <li>(f) the follow-up study is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient</li> </ul>	
	Applicable only once in any 12 month period	
12207	<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> <ul style="list-style-type: none"> <li>(a) the patient is referred by a medical practitioner; and</li> <li>(b) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner before the investigation; and</li> <li>(c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures:               <ul style="list-style-type: none"> <li>(i) airflow;</li> </ul> </li> </ul>	611.80

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<ul style="list-style-type: none"> <li>(ii) continuous EMG;</li> <li>(iii) anterior tibial EMG;</li> <li>(iv) continuous ECG;</li> <li>(v) continuous EEG;</li> <li>(vi) EOG;</li> <li>(vii) oxygen saturation;</li> <li>(viii) respiratory movement (chest and abdomen);</li> <li>(ix) position; and</li> </ul> <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> <ul style="list-style-type: none"> <li>(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</li> <li>(ii) stored for interpretation and preparation of a report; and</li> </ul> <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 described in any of items 11000 to 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>	
	Applicable only once in any 12 month period	
12208	<p>Overnight investigation for sleep apnoea for at least 8 hours, for a patient aged 18 years or more, if:</p> <ul style="list-style-type: none"> <li>(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</li> <li>(b) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</li> <li>(c) there is continuous monitoring and recording, in accordance with current professional guidelines, of the following measures: <ul style="list-style-type: none"> <li>(i) airflow;</li> <li>(ii) continuous EMG;</li> <li>(iii) anterior tibial EMG;</li> <li>(iv) continuous ECG;</li> </ul> </li> </ul>	611.80

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(v) continuous EEG; (vi) EOG; (vii) oxygen saturation; (viii) respiratory movement (chest and abdomen); (ix) position; and (d) polygraphic records are: (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 (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 (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 (g) the investigation is not provided to the patient on the same occasion that a service described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 or 12250 is provided to the patient <i>Applicable only once in any 12 month period</i>	
12210	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,	730.30

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>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: 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 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, 11713, 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>	
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> <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> <p style="padding-left: 20px;">(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</p>	657.90

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Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	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, 11713, 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	
12215	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: (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 paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient; and	730.30

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**Group D1—Miscellaneous diagnostic procedures and investigations**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	<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 style="margin-left: 20px;">(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 style="margin-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 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, 11713, 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>	
12217	<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 style="margin-left: 20px;">(i) airflow;</p> <p style="margin-left: 20px;">(ii) continuous EMG;</p> <p style="margin-left: 20px;">(iii) ECG;</p> <p style="margin-left: 20px;">(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</p> <p style="margin-left: 20px;">(v) EOG;</p> <p style="margin-left: 20px;">(vi) oxygen saturation;</p> <p style="margin-left: 20px;">(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</p> <p style="margin-left: 20px;">(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="margin-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</p>	657.90

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Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<p>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 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>(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>(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, 11713, 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>	
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>(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 clinical screening tool results; 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 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> <p>(i) airflow;</p>	348.85

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<ul style="list-style-type: none"> <li>(ii) continuous EMG;</li> <li>(iii) continuous ECG;</li> <li>(iv) continuous EEG;</li> <li>(v) EOG;</li> <li>(vi) oxygen saturation;</li> <li>(vii) respiratory effort; and</li> </ul> <p>(c) the investigation is performed under the supervision of a qualified adult sleep medicine practitioner; and</p> <p>(d) either:</p> <ul style="list-style-type: none"> <li>(i) the equipment is applied to the patient by a sleep technician; or</li> <li>(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</li> </ul> <p>(e) polygraphic records are:</p> <ul style="list-style-type: none"> <li>(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</li> <li>(ii) stored for interpretation and preparation of a report; and</li> </ul> <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 described in any of items 11000 to 11005, 11503, 11704, 11705, 11707, 11713, 11714, 11716, 11717, 11723, 11735 and 12203 is provided to the patient</p>	
	Applicable only once in any 12 month period	
12254	<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> <ul style="list-style-type: none"> <li>(i) airflow;</li> <li>(ii) continuous EMG;</li> <li>(iii) anterior tibial EMG;</li> <li>(iv) continuous ECG;</li> <li>(v) continuous EEG;</li> <li>(vi) EOG;</li> </ul>	950.70

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<ul style="list-style-type: none"><li>(vii) oxygen saturation;</li><li>(viii) respiratory movement (chest and abdomen);</li><li>(ix) position; and</li></ul> <p>(c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 nap periods are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; 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> <ul style="list-style-type: none"><li>(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</li><li>(ii) stored for interpretation and preparation of a report; and</li></ul> <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>	
12258	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness in a patient aged 18 years or more, if: <ul style="list-style-type: none"><li>(a) a qualified adult sleep medicine practitioner or neurologist determines that testing is necessary to objectively confirm the ability to maintain wakefulness; and</li><li>(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:<ul style="list-style-type: none"><li>(i) airflow;</li><li>(ii) continuous EMG;</li><li>(iii) anterior tibial EMG;</li><li>(iv) continuous ECG;</li><li>(v) continuous EEG;</li><li>(vi) EOG;</li><li>(vii) oxygen saturation;</li><li>(viii) respiratory movement (chest and abdomen);</li><li>(ix) position; and</li></ul></li><li>(c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and</li><li>(d) a sleep technician is in continuous attendance under the supervision of a qualified adult sleep medicine practitioner; and</li></ul>	950.70

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	<p>(e) 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>(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>	
12261	<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: 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> <p style="padding-left: 20px;">(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 nap periods are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; 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: 20px;">(i) analysed (for assessment of sleep stage, and maturation of</p>	996.85

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	<p>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 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>	
12265	<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>(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> <p>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</p> <p>(c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; 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>(i) analysed (for assessment of sleep stage, arousals, respiratory events, cardiac abnormalities and limb movements) with manual scoring, or manual correction of computerised scoring</p>	996.85

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**Group D1—Miscellaneous diagnostic procedures and investigations**

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Column 1 Item	Column 2 Description	Column 3 Fee (\$)
	<ul style="list-style-type: none"> <li>in epochs of not more than 1 minute; and</li> <li>(ii) stored for interpretation and preparation of a report; and</li> <li>(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</li> <li>(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</li> </ul> <p>Applicable only once in a 12 month period</p>	
12268	<p>Multiple sleep latency test for the assessment of unexplained hypersomnolence for a patient less than 12 years of age, if:</p> <ul style="list-style-type: none"> <li>(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</li> <li>(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: <ul style="list-style-type: none"> <li>(i) airflow;</li> <li>(ii) continuous EMG;</li> <li>(iii) ECG;</li> <li>(iv) EEG (with a minimum of 4 EEG leads or, in selected investigations, a minimum of 6 EEG leads);</li> <li>(v) EOG;</li> <li>(vi) oxygen saturation;</li> <li>(vii) respiratory movement of rib and abdomen (whether movement of rib is recorded separately from, or together with, movement of abdomen);</li> <li>(viii) measurement of carbon dioxide (either end-tidal or transcutaneous); and</li> </ul> </li> <li>(c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 nap periods are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and</li> <li>(d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and</li> <li>(e) polygraphic records are: <ul style="list-style-type: none"> <li>(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</li> <li>(ii) stored for interpretation and preparation of a report; and</li> </ul> </li> <li>(f) interpretation and preparation of a permanent report is provided by a</li> </ul>	1,069.20

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Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	qualified paediatric sleep medicine practitioner with personal direct review of raw data from the original recording of polygraphic data from the patient; and  (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  Applicable only once in a 12 month period	
12272	Maintenance of wakefulness test for the assessment of the ability to maintain wakefulness for a patient less than 12 years of age, if:  (a) a qualified paediatric sleep medicine practitioner determines that testing to objectively confirm the ability to maintain wakefulness is necessary; and  (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: (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  (c) immediately following the overnight assessment, a daytime assessment is performed where at least 4 wakefulness trials are conducted, during which there is continuous recording of EMG, ECG, EEG and EOG; and  (d) a sleep technician is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; and  (e) polygraphic records are: (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  (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  (g) the diagnostic assessment is not provided to the patient on the same occasion that a service described in item 11003, 12210, 12215 or	1,069.20

General medical services table **Schedule 1**  
Diagnostic procedures and investigations **Part 4**  
Group D1: Miscellaneous diagnostic procedures and investigations **Division 4.1**

Clause 4.1.5

<b>Group D1—Miscellaneous diagnostic procedures and investigations</b>		
<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	12268 is provided to the patient Applicable only once in a 12 month period	
12306	Bone densitometry, using dual energy X-ray absorptiometry, involving the measurement of 2 or more sites (including interpretation and reporting), for: (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 (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 For any particular patient, once only in a 24 month period	106.55
12312	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: (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; other than a service associated with a service to which item 12306, 12315 or 12321 applies For any particular patient, once only in a 12 month period	106.55
12315	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: (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; other than a service associated with a service to which item 12306, 12312 or 12321 applies For any particular patient, once only in a 24 month period	106.55
12320	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 the measurement of bone mineral density, if:	106.55

Schedule 1 General medical services table

Part 4 Diagnostic procedures and investigations

Division 4.1 Group D1: Miscellaneous diagnostic procedures and investigations

Clause 4.1.5

**Group D1—Miscellaneous diagnostic procedures and investigations**

<b>Column 1 Item</b>	<b>Column 2 Description</b>	<b>Column 3 Fee (\$)</b>
	(a) the patient is 70 years of age or over; and (b) either: (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; other than a service associated with a service to which item 12306, 12312, 12315, 12321 or 12322 applies For any particular patient, once only in a 5 year period	
12321	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: (a) established low bone mineral density; or (b) confirming a presumptive diagnosis of low bone mineral density made on the basis of one or more fractures occurring after minimal trauma; other than a service associated with a service to which item 12306, 12312 or 12315 applies For any particular patient, once only in a 12 month period	106.55
12322	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: (a) the patient is 70 years of age or over; and (b) the t-score for the patient's bone mineral density is less than -1.5 but more than -2.5; other than a service associated with a service to which item 12306, 12312, 12315, 12320 or 12321 applies For any particular patient, once only in a 2 year period	106.55
12325	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: (a) the patient is of Aboriginal and Torres Strait Islander descent; and (b) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient's diabetes; and (c) this item and item 12326 have not applied to the patient in the preceding 12 months; and (d) the patient does not have: (i) an existing diagnosis of diabetic retinopathy; or (ii) visual acuity of less than 6/12 in either eye; or (iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation	52.00

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**Group D1—Miscellaneous diagnostic procedures and investigations**

Column 1 Item	Column 2 Description	Column 3 Fee (\$)
12326	Assessment of visual acuity and bilateral retinal photography with a non-mydratric 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: <ul style="list-style-type: none"> <li>(a) the assessment is performed by the medical practitioner (other than an optometrist or ophthalmologist) providing the primary glycaemic management of the patient’s diabetes; and</li> <li>(b) this item and item 12325 have not applied to the patient in the preceding 24 months; and</li> <li>(c) the patient does not have:               <ul style="list-style-type: none"> <li>(i) an existing diagnosis of diabetic retinopathy; or</li> <li>(ii) visual acuity of less than 6/12 in either eye; or</li> <li>(iii) a difference of more than 2 lines of vision between the 2 eyes at the time of presentation</li> </ul> </li> </ul>	52.00

**Division 4.2—Group D2: Nuclear medicine (non-imaging)**

**4.2.1 Restriction on items in Group D2—services connected with services in item 12250**

An item in Group D2 does not apply to a service described in the item if the service is provided at the same time as, or in connection with, the service described in item 12250.

**4.2.2 Items in Group D2**

This clause sets out items in Group D2.

Note: The fees in Group D2 are indexed in accordance with clause 1.3.1.

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**Group D2—Nuclear medicine (non-imaging)**

Column 1 Item	Column 2 Description	Column 3 Fee (\$)
12500	Blood volume estimation	225.40
12524	Renal function test (without imaging procedure)	164.75
12527	Renal function test (with imaging and at least 2 blood samples)	88.40
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: <ul style="list-style-type: none"> <li>(a) the confirmation of <i>Helicobacter pylori</i> colonisation; or</li> <li>(b) the monitoring of the success of eradication of <i>Helicobacter pylori</i> in patients with peptic ulcer disease;</li> </ul>	88.10

**Schedule 1** General medical services table  
**Part 4** Diagnostic procedures and investigations  
**Division 4.2** Group D2: Nuclear medicine (non-imaging)

Clause 4.2.2

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**Group D2—Nuclear medicine (non-imaging)**

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<b>Column 1</b>	<b>Column 2</b>	<b>Column 3</b>
<b>Item</b>	<b>Description</b>	<b>Fee (\$)</b>
	(other than a service associated with a service to which item 66900 applies)	

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