

WorkCoverSA

# Medical Schedule 1A guidelines

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### **Disclaimer**

The information in this publication is compiled by WorkCover Corporation of South Australia. The data and facts referred to are correct at the time of publishing and provided as general information only. It is not intended that any opinion as to the meaning of legislation referred to is to be relied upon by readers who should seek independent advice as to any specific issues relevant to you, your workplace or organisation.

### **Important notice**

These guidelines must be read in conjunction with WorkCover's Medical Fee Schedule 1A which utilises the Medicare Benefits Schedule (MBS) item numbers, descriptions and payment rules with permission from the Commonwealth of Australia.

WorkCover has also amended some descriptions and rules from the MBS where appropriate, to ensure they are relevant to the South Australian workers compensation environment.

If a medical practitioner is authorised by Medicare to access specific item numbers, then unless stated otherwise, the medical practitioner can utilise the same service provisions in WorkCover's Medical Fee Schedule 1A. This authorisation does not apply to any other WorkCover schedule.

The term 'this schedule' throughout this document refers to the WorkCover Medical Fee Schedule 1A as published in the Government Gazette.

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## Introduction

### G.2.1. Provider eligibility for WorkCover

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

- (a) be a recognised specialist, consultant physician or general practitioner; or
- (b) be in an approved placement under section 3GA of the *Health Insurance Act 1973*; or
- (c) be a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973*, and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above is not a medical practitioner for WorkCover purposes and WorkCover fees cannot be paid for their services. This does not affect the practitioner's ability to prescribe, refer or order diagnostic test etc. NOTE: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

### G.5.1. Recognition as a Specialist or Consultant Physician

A medical practitioner who:

- is registered as a specialist in accordance with the Health Practitioner Regulation National Law or any other authorising body and who appears on the Medical Board of Australia specialist register, excluding general practitioners.

### G.5.2. Emergency Medicine

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

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

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

### **G.6.1. Referral of Patients to Specialists or Consultant Physicians**

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

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

#### **What is a Referral?**

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

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

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

The exceptions to the requirements in paragraph above are that

- (a) sub-paragraphs (i),(ii) and (iii) do not apply to
  - a pre-anaesthesia consultation by a specialist anaesthetist (items 16710-17625);
- (b) sub-paragraphs (ii) and (iii) do not apply to
  - a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
  - an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and
- (c) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

#### **Examination by Specialist Anaesthetists**

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

## Who can Refer?

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

Referrals are to be made as follows:-

- (a) to a recognised consultant physician -
  - (i) by another medical practitioner; or
  - (ii) by an approved dental practitioner <sup>1</sup> (oral surgeon), where the referral arises out of a dental service;
- (b) to a recognised specialist -
  - (i) by another medical practitioner; or
  - (ii) by a registered dental practitioner <sup>2</sup>, where the referral arises out of a dental service; or
  - (iii) by a registered optometrist where the specialist is an ophthalmologist.

<sup>1</sup>See paragraph OB.1 for the definition of an approved dental practitioner.

<sup>2</sup>A registered dental practitioner is a dentist registered with the Dental Board of the State or Territory where s/he practices. A registered dental practitioner may or may not be an approved dental practitioner.

## Billing

### ***Routine Referrals***

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

- name and either practice address or provider number of the referring practitioner;
- date of referral; and
- period of referral (when other than for 12 months) expressed in months, eg "3", "6" or "18" months, or "indefinitely" should be shown.

### ***Special Circumstances***

#### *(i) Lost, stolen or destroyed referrals.*

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

#### *(ii) Emergencies*

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

*(iii) Hospital referrals.*

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

**Public Hospital Patients**

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

**Period for which Referral is Valid**

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

**Specialist Referrals**

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

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

**Referrals by other Practitioners**

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

**Definition of a Single Course of Treatment**

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

the consultant physician that may be necessary. Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

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

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

However, where the referring practitioner:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
- (c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

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

### **Locum-tenens Arrangements**

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

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

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

### **G.7.1. Billing procedures**

#### **Itemised Accounts**

Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to claim WorkCover fees. Please refer to the account and invoicing standards in WorkCover's Medical fee schedule.

**G.10.1. Schedule fees**

WorkCover fees are determined for each medical service. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in Schedule 1A is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

**G.11.1. Services not listed**

Fees are not generally payable for services not listed in this schedule. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract fees on an attendance basis. For example, intramuscular injections, aspiration needle biopsy, treatment of seborrheic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe). NB: Services in Schedule 1B may apply.

**G.12.1. Professional services**

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

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

- (a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
- (b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
- (c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);
- (d) Item 15600 in Group T2 (Radiation Oncology);
- (e) All Group T3 (Therapeutic Nuclear Medicine) items;
- (f) All Group T4 (Obstetrics) items (except 16400 and 16514);
- (g) All Group T6 (Anaesthetics) items;
- (h) All Group T7 (Regional or Field Nerve Block) items;

- (i) All Group T8 (Operations) items;
- (j) All Group T9 (Assistance at Operations) items;
- (k) All Group T10 (Relative Value Guide for Anaesthetics) items.

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

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

### **G.12.2. Services rendered on behalf of medical practitioners**

Medical services in Categories 2 and 3 not included in the list above and Category 5 (Diagnostic Imaging) services continue to attract fees if the service is rendered by:-

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

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

So that a service rendered by an employee or under the supervision of a medical practitioner may attract a fee, the service must be billed in the name of the practitioner who must accept full responsibility for the service. While the supervising medical practitioner need not be present for the entire service, they must have a direct involvement in at least part of the service. Although the supervision requirements will vary according to the service in question, they will, as a general rule, be satisfied where the medical practitioner has:-

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

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

### **G.13.1. Services which do not attract WorkCover fees**

#### **Services not attracting fees**

- telephone consultations other than those in Schedule 1B;
- issue of repeat prescriptions when the patient does not attend the surgery in person;
- group attendances (unless otherwise specified in the item, such as items 170, 171, 172, 342, 344 and 346);
- non-therapeutic cosmetic surgery;

- euthanasia and any service directly related to the procedure. However, services rendered for counselling/assessment about euthanasia will attract fees.

### **Pain pumps for post-operative pain management**

The cannulation and/or catheterisation of surgical sites associated with pain pumps for post-operative pain management cannot be billed under any Schedule 1A item.

The filling or re-filling of drug reservoirs of ambulatory pain pumps for post-operative pain management cannot be billed under any Schedule 1A items.

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

Generally, WorkCover fees are not paid for professional services rendered by a medical practitioner to dependants or partners or a partner's dependants.

#### **G.14.1. Principles of interpretation of this schedule**

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

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

#### **G.14.2. Services attracting fees on an attendance basis**

Some services are not listed in this schedule because they are regarded as forming part of a consultation or they attract fees on an attendance basis. NB: Services in Schedule 1B may apply.

#### **G.14.3. Consultation and procedures rendered at the one attendance**

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

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

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

**G.14.4. Aggregate items**

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

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

**G.14.5. Residential aged care facility**

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

**G.15.1. Practitioners should maintain adequate and contemporaneous records**

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

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

- clearly identify the name of the patient; and
- contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated; and
- each entry needs to provide clinical information adequate to explain the type of service rendered or initiated; and
- each entry needs to be sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care.

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

**Category 1 - Professional attendances****A.1.. Personal Attendance by Practitioner**

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

## **A.2.. Professional Attendances**

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

## **A.3.. Services not Attracting WorkCover fees**

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

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

## **A.4.. Multiple Attendances on the Same Day**

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

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

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

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

## **A.5.. Attendances by General Practitioners (Items 3 to 51, 193, 195, 197, 199, 597, 599, 2497-2559 and 5000-5067)**

Items 3 to 51 and 193, 195, 197, 199, 597, 599, 2497-2559 and 5000-5067 relate specifically to attendances rendered by medical practitioners.

Only general practitioners are eligible to itemise the *Group A1, items 597 and 599 of Group A11 and Group A22* content-based items. To assist general practitioners in selecting the appropriate item number for payment purposes the following notes in respect of the various levels are given.

**LEVEL A**

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

**LEVEL B**

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

**LEVEL C**

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

**LEVEL D**

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

***Counselling or Advice to Patients or Relatives***

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

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

Items 5906 to 5912 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

***Recording Clinical Notes***

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

***Other Services at the Time of Attendance***

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

**A.6.. Professional Attendances at an Institution (Items 4, 24, 37, 47, 58, 59, 60, 65, 5003, 5023, 5043, 5063, 5220, 5223, 5227 and 5228)**

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

(a) disadvantaged children; (b) juvenile offenders; (c) aged persons; (d) chronically ill psychiatric patients; (e) homeless persons; (f) unemployed persons; (g) persons suffering from alcoholism; (h) persons addicted to drugs; or (i) physically or intellectually disabled persons.

**A.7.. Attendances at a Hospital (Items 4, 24, 37, 47, 58, 59, 60, 65)**

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

**A.8.. Residential Aged Care Facility Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96, 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267)**

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

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

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

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

**A.9.. Attendances at Hospitals, Residential Aged Care Facility and Institutions and Home Visits**

To facilitate assessment of the correct fee in respect of a number of patients attended on the one occasion at one of the above locations, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment form. For example, where ten patients were visited (for a brief consultation) in the one residential aged care facility on the one occasion, each account, receipt or assignment form would show "Item 20 - 1 of 10 patients" for a General Practitioner.

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

**A.10.. After-Hours Attendances (Items 597, 598, 599, 600, 5000, 5003, 5010, 5020, 5023, 5028, 5040, 5043, 5049, 5060, 5063, 5067, 5220, 5223, 5228, 5260, 5263 and 5265)**

After hours attendance items may be claimed as follows:

Items 597, 598, 599, 600 apply only to a professional attendance that is provided:

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

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

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

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

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

*Urgent After Hours Attendances (Items 597- 600)*

Items 597, 598, 599 and 600 can be used for urgent services provided in consulting rooms, or at a place other than consulting rooms, in an after hours period.

Urgent After Hours Attendances (Items 597 and 598) allow for urgent attendances (other than an attendance between 11pm and 7am) in an after hours period.

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

The attendance for all these items must be requested by the patient or a responsible person in, or not more than 2 hours before the start of the same unbroken urgent after hours period. The patient's condition must require urgent medical treatment and if the attendance is undertaken at consulting rooms, it is necessary for the practitioner to return to, and specially open the consulting rooms for the attendance.

If more than one patient is seen on the one occasion, the standard after-hours attendance items should be used in respect of the second and subsequent patients attended on the same occasion.

Medical practitioners who routinely provide services to patients in the after-hours periods at consulting rooms, or who provide the services (as a contractor, employee, member or otherwise) for a general practice or clinic that routinely provides services to patients in after-hours periods at consulting rooms will not be able to bill urgent after hours items 597, 598, 599 and 600.

*Non-Urgent After Hours Attendances (5000 – 5063 and 5220 - 5267)*

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

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

Attendance Period	Applicable Time			Items
	Monday to Friday*	Saturday*	Sunday and/or public holiday	
Urgent after-hours attendance	Between 7am - 8am and 6pm - 11pm	Between 7am - 8am and 12 noon - 11pm	Between 7am - 11pm	597, 598
Urgent after-hours in unsociable hours	Between 11pm - 7am	Between 11pm - 7am	Between 11pm - 7am	599, 600
Non-urgent After hours In consulting rooms	Before 8am or after 8pm	Before 8am or after 1pm	24 hours	5000, 5020 5040, 5060 5200, 5203, 5207, 5208
Non-urgent After hours at a place other than consulting rooms	Before 8am or after 6pm	Before 8am or after 12 noon	24 hours	5003, 5010, 5023, 5028 5043, 5049, 5063, 5067 5220 - 5267

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

**A.11.. Minor Attendance by a Consultant Physician (Items 119, 131)**

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

- hospital visits where a physical examination does not result, or where only a limited examination is performed;
- hospital visits where a significant alteration to the therapy or overall management plan does not ensue;

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

#### **A.12.. Referred Patient Consultant Physician Treatment and Management Plan (Items 132 and 133)**

Patients with at least two morbidities which can include complex cases are eligible for these services when referred by their referring practitioner.

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

Item 132 is only available once in the preceding 12 months. Should further reviews of the consultant physician treatment and management plan be required, the appropriate item for such service/s is 116.

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

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

#### **REFERRED PATIENT CONSULTANT PHYSICIAN TREATMENT AND MANAGEMENT PLAN**

The following content outline is required to be sent back to the referring practitioner. The consultant physician treatment and management plan must also address any specific questions and issues raised by the referring practitioner.

##### **History**

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

##### **Examination**

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

##### **Diagnosis**

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

## **Management plan**

### *Treatment options/Treatment plan*

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

### *Medication recommendations*

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

### *Social measures*

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

### *Other non medication measures*

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

### *Indications for review*

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

### *Longer term management*

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

## **A.13.. Referred patient assessment, diagnosis and treatment and management plan for autism or any other pervasive developmental disorder (items 135 and 289)**

Items 135 or 289 are available on referral from a medical practitioner for consultant paediatricians or psychiatrists to provide early diagnosis and treatment of autism or any other pervasive development

disorders (PDD) for children aged under 13 years. Both items include assessment, diagnosis and the creation of a treatment and management plan. The treating practitioner can access assistance from allied health professionals (psychologists, occupational therapists and speech pathologists), where appropriate, to collaborate in both the diagnosis and treatment of autism or any other pervasive developmental disorder. Items 135 or 289 are claimable only once per patient per lifetime, where there is no existing claim for a PDD treatment and management plan.

The diagnosis, assessment and treatment and management plan should be explained, discussed and a copy of the plan provided to the patient and their family and/or carer(s).

Where the patient presents with another morbidity in addition to PDD, item 132 can be used. However, the use of this item will not provide access to assistance with assessment, diagnosis and treatment from allied health professionals (AHP).

### **Referred Patient Treatment and Management Plan Guidelines**

It is advisable before using item 135 or 289 that practitioners familiarise themselves with the “*Guidelines for the assessment of autistic spectrum disorders in Australia*”. Practitioners can access these guidelines online at: <http://www.med.monash.edu.au/spppm/research/devpsych/actnow/factsheet15.html>

Practitioners should have regard to these guidelines and the DSM IV classification of pervasive developmental disorder in establishing the diagnosis and conducting the assessment.

For the management plan, a risk assessment involves assessment of the risk of a contributing co-morbidity as well as environmental, physical, social and emotional risk factors to the patient or to others.

The need for medication should also be considered where appropriate.

If the patient’s care needs do not require a treatment and management plan, treatment can be provided under existing attendance items for consultant psychiatrists and paediatricians.

### **Referral requirements**

Items 135 or 289 should be used for both diagnosis and treatment of autism or any other PDD where clinically appropriate. A consultant paediatrician or psychiatrist may claim any of items 110-131 or 296-370 (excluding 359), where appropriate, to seek assistance with diagnosis from an AHP.

The referral to an AHP for early intervention treatment must be made by a consultant paediatrician or psychiatrist, either as an outcome of the service provided under one of items 110-131, 296-370 (excluding 359), 135 or 289. There must be a claim for the patient for items 135 or 289 at the time of, or prior to the attendance for referral for AHP early intervention treatment.

### **Allied health assistance with diagnosis and treatment**

An allied health professional may provide up to a maximum of four (4) services per child when providing assistance with assessment and diagnosis and up to a maximum of twenty (20) services for early intervention treatment.

Allied health diagnosis services may be provided to a child aged under 13 years. Allied health early intervention treatment services may be provided to a child aged under 15 years, if the PDD treatment plan prepared by a paediatrician or psychiatrist is complete prior to the child's 13<sup>th</sup> birthday.

Where the expertise of allied health professionals is drawn upon subsequent to a claim for items 135 or 289, any resulting review of the treatment and management plan should be completed under existing attendance items for consultant paediatricians or psychiatrists. For consultant paediatricians, this excludes item 133, which is exclusively for the review of a patient seen under item 132.

The extent of the services accessed by the consultant paediatrician or psychiatrist for diagnosis or early intervention treatment, and the decision regarding which allied health professionals to include, is a matter for the clinical judgement of the consultant paediatrician or psychiatrist.

### **Existing patients or patients with an existing diagnosis**

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

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

### **A.14.. Geriatrician Referred Patient Assessment and Management Plan (Items 141-147)**

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

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

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

- current active medical problems; past medical history; medication review; immunisation status; advance care planning arrangements;
- current and previous physical function including personal, domestic and community activities of daily living; psychological function including cognition and mood; and
- social function including living arrangements, financial arrangements, community services, social support and carer issues.

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

Some of the information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the geriatrician. The

remaining components of the assessment and development of the management plan must include a personal attendance by the geriatrician.

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

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

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

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

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

#### **A.15.. Prolonged Attendance in Treatment of a Critical Condition (Items 160 - 164)**

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

- (i) the patient must be in imminent danger of death;
- (ii) if the personal attendance is not continuous, the occasion on which the service is provided is taken to be the total time of the attendance; and
- (iii) if personal attendance on a single patient is provided by 1 or more medical practitioners concurrently, each practitioner may claim an attendance fee.

#### **A.16.. Family Group Therapy (Items 170, 171, 172)**

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

#### **A.17.. Acupuncture (Item 173, 193, 195, 197 and 199)**

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

- (a) the person maintains accreditation as a Medical Acupuncturist with the Joint Consultative Committee on Medical Acupuncture (JCCMA); and
- (b) the Royal Australian College of General Practitioners (RACGP) has determined that the person meets the skills requirements for providing services to which the items apply.

Item 173 does not require a medical practitioner to have accreditation with the JCCMA. Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service "acupuncture" is provided.

For the purpose of payment "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, eg by application of ultrasound, laser beams, pressure or moxibustion, etc.

*For more information on the content-based item structure used in this Group, see A.5 in these guidelines.*

**A.18.. Referred Patient Assessment and Management Plan, Initial Consultations for NEW PATIENTS (Items 296 to 299 and 361) and Referral to Allied Health Professionals (for new and continuing patients) - (Items 291, 293 and 359)**

Referral for items 291, 293 and 359 should be through the general practitioner for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP.

In order to facilitate ongoing patient focussed management, an outcome tool will be utilised during the assessment and review stage of treatment, where clinically appropriate. The choice of outcome tools to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

- Kessler Psychological Distress Scale (K10); Short Form Health Survey (SF12); Health of the Nation Outcome Scales (HoNOS)

Preparation of the management plan should be in consultation with the patient. If appropriate, a written copy of the management plan should be provided to the patient. A written copy of the management plan should be provided to the general practitioner within a maximum of two weeks of the assessment. It should be noted that two weeks is the outer limit and in more serious cases more prompt provision of the plan and verbal communication with the GP may be appropriate. A guide to the content of the report which should be provided to the GP under this item is included within this Schedule.

It is expected that item 291 will be a single attendance. However, there may be particular circumstances where a patient has been referred by a GP for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, items 296, 297, 299 or 361 (for a new patient) or 300-308 (for continuing patients) may be used, and item 291 may be used subsequently, in those circumstances where the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) prior to the consultation for providing the referring medical practitioner with an assessment and management plan. It is not intended that items 296, 297, 299, 361 or 300-308 will generally or routinely be used in conjunction with, or prior to, item 291.

Items 293 and 359 are available in instances where the GP initiates a review of the plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines, Note: This information is provided as a guide only and each case should be addressed according to a patient's individual needs. An electronic version of the Guidelines is available on the RANZCP website at [www.ranzcp.org](http://www.ranzcp.org)

## **REFERRED PATIENT ASSESSMENT AND MANAGEMENT PLAN**

### **Preliminary**

- The following content outline is indicative of what would usually be sent back to GPs.
- The Management plan should address the specific questions and issues raised by the GP.
- In most cases the patient is usually well known by the GP.

### **History and Examination**

This should focus on the presenting symptoms and current difficulties, including precipitating and ongoing stresses; and only briefly mention any relevant aspects of the patient's family history, developmental history, personality features, past psychiatric history and past medical history.

It should contain a comprehensive relevant Mental Status Examination and any relevant pathology results if performed.

It should summarise any psychological tests that were performed as part of the assessment.

### **Diagnosis**

A diagnosis should be made either using ICD 10 or DSM IV classification. In some cases the diagnosis may differ from that stated by the GP, and an explanation of why the diagnosis differs should be included.

### **Psychiatric formulation**

A brief integrated psychiatric formulation focussing on the biological, psychological and physical factors. Any precipitant and maintaining factors should be identified including relevant personality factors. Protective factors should also be noted. Issues of risk to the patient or others should be highlighted.

### **Management plan**

#### **1. Education**

Include a list of any handout material available to help people understand the nature of the problem. This includes recommending the relevant RANZCP consumer and carer clinical practice guidelines.

#### **2. Medication recommendations**

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

### 3. **Psychotherapy**

Recommendations should be given on the most appropriate mode of psychotherapy required, such as supportive psychotherapy, cognitive and behavioural psychotherapy, family or relationship therapy or intensive explorative psychotherapy. This should include recommendations on who should provide this therapy.

### 4. **Social measures**

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

### 5. **Other non medication measures**

This may include other options such as life style changes including exercise and diet, any rehabilitation recommendations, discussion of any complementary medicines, reading recommendations, relationship with other support services or agencies etc.

### 6. **Indications for re-referral**

It is anticipated that the majority of patients will be able to be managed effectively by the GP using the plan. If there are particular concerns about the possible need for further review, these should be noted.

### 7. **Longer term management**

Provide a longer term management plan listing alternative measures that might be taken in the future if the clinical situation changes. This might be articulated as a relapse signature and relapse drill, and should include drug doses and other indicated interventions, expected response times, adverse effects and interactions.

### **Initial Consultation for a NEW PATIENT (item 296 in rooms, item 297 at hospital, item 299 for home visits and 361 for telepsychiatry)**

The rationale for items 296 – 299 and 361 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for items 296 – 299 and 361 may be from a medical practitioner practising in general practice, a specialist or another consultant physician.

It is intended that either item 296, 297, 299 or 361 will apply once only for each new patient on the first occasion that the patient is seen by a consultant psychiatrist, **unless** the patient is referred by a medical practitioner practising in general practice for an assessment and management plan, in which case the consultant psychiatrist, if he or she agrees that the patient is suitable for management in a general practice setting, will use item 291 where an assessment and management plan is provided to the referring practitioner.

There may be particular circumstances where a patient has been referred by a GP to a consultant psychiatrist for an assessment and management plan, but it is not possible for the consultant psychiatrist to determine in the initial consultation whether the patient is suitable for management under such a plan. In these cases, where clinically appropriate, item 296, 297, 299 or 361 (for a new patient) or 300-308 (for continuing patients) may be used and item 291 may be used subsequently, in those circumstances where

the consultant psychiatrist undertakes a consultation (in accordance with the item requirements) and provides the referring medical practitioner with an assessment and management plan. It is not generally intended that item 296, 297, 299 or 361 will be used in conjunction with, or prior to, item 291.

Use of items 296 - 299 and 361 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

Items 300 - 308 are available for consultations in consulting rooms other than those provided under item 296, and items 291, 293 and 359. Similarly time tiered items remain available for hospital, home visits and telepsychiatry. These would cover a new course of treatment for patients who have already been seen by the consultant psychiatrist in the preceding 24 months as well as subsequent consultations for all patients.

#### **A.19.. Psychiatric Attendances (Item 319)**

Fees are attracted under Item 319 only where patients are diagnosed as suffering from:

- severe personality disorder (predominantly from cluster B groupings), or in persons under 18 years of age a severe disruption of personality development; or
- anorexia nervosa; or
- bulimia nervosa; or
- dysthymic disorder; or
- substance-related disorder; or
- somatoform disorder; or
- a pervasive developmental disorder (including autism and Asperger's disorder) according to the relevant criteria set out in the Diagnostic and Statistical Manual of the American Psychiatric Association - Fourth Edition (DSM-IV).

It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment. Once a patient is identified as meeting the criteria of item 319, he/she continues to be eligible under that item for the duration of the current course of treatment (provided that attendances under **items 300 to 308 and 319** do not exceed 160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to item 319 is the patient's score as assessed during the new course of treatment.

In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.

It is the responsibility of the psychiatrist to ensure that the patient meets these criteria.

When a patient who meets the criteria defined in item 319 attends a psychiatrist on more than 160 occasions in a calendar year, such attendances would be covered by items 310 to 318.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has undertaken to establish an appropriate mechanism to enable use of item 319 by suitably trained psychiatrists. In the interim it is expected that psychiatrists whose usual practice includes long term intensive treatment of patients whose diagnoses meet the criteria defined in the item will be using item 319.

On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in a calendar year.

**A.20.. Interview of Person other than a Patient by Consultant Psychiatrist (Items 348, 350, 352)**

Items 348 and 350 refer to investigative interviews of a patient's relatives or close associates to determine whether the particular problem with which the patient presented was focused in the patient or in the interaction between the patient and the person being interviewed. These items do not cover counselling of family or friends of the patient. The term "in the course of initial diagnostic evaluation of the patient" should normally be interpreted as extending for up to one month from the date of the initial consultation. There is no strict limit to the number of interviews or persons interviewed in that period. These items should not be used for interviews concerned with the continuing management of the patient.

Item 352 refers to investigative interviews of a patient's relatives or close associates to focus on a particular clinically relevant problem arising in the continuing management of the patient. This item does not cover counselling of family or friends of the patient. Payment under this item is limited to four in any twelve month period.

Fees are payable for Item 348, 350 or 352 and for a consultation with a patient (items 300 - 328) on the same day provided that separate attendances are involved.

Charges relating to services covered by items 348, 350 and 352 should be raised against the patient rather than against the person interviewed.

**A.21.. Consultant Occupational Physician Attendances (Items 385 to 388)** refer to items 110 – 128 in WorkCover's Medical Fee Schedule.

**A.22.. Contact Lenses (Items 10801-10809)**

Fees are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie patients with certain conditions). The classes of patients eligible for payment for contact lens consultations are described in items 10801 to 10809.

Fees are not payable for item 10809 in circumstances where patients want contact lenses only for:

- (a) reasons of appearance (because they do not want to wear spectacles);
- (b) sporting purposes;
- (c) work purposes; or

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

Fees are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses. Subsequent follow-up attendances attract fees on a consultation basis.

**A.23.. Refitting of Contact Lenses (Item 10816)**

This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structure or functional change in the eye or an allergic response.

**A.24.. Health Assessments (Items 701, 703, 705, 707)**

There are four time-based health assessment items, consisting of brief, standard, long and prolonged consultations.

**Brief Health Assessment (Item 701)**

A brief health assessment is used to undertake simple health assessments. The health assessment should take no more than 30 minutes to complete.

**Standard Health Assessment (Item 703)**

A standard health assessment is used for straightforward assessments where the patient does not present with complex health issues but may require more attention than can be provided in a brief assessment. The assessment lasts more than 30 minutes but takes less than 45 minutes.

**Long Health Assessment (Item 705)**

A long health assessment is used for an extensive assessment, where the patient has a range of health issues that require more in-depth consideration, and longer-term strategies for managing the patient’s health may be necessary. The assessment lasts at least 45 minutes but less than 60 minutes.

**Prolonged Health Assessment (MBS Item 707)**

A prolonged health assessment is used for a complex assessment of a patient with significant, long-term health needs that need to be managed through a comprehensive preventive health care plan. The assessment takes 60 minutes or more to complete.

Medical practitioners may select one of the health assessment items to provide a health assessment service to a member of any of the target groups listed in the table below. The health assessment item that is selected will depend on the time taken to complete the health assessment service. This is determined by the complexity of the patient’s presentation and the specific requirements that have been established for each target group eligible for health assessments.

Items 701, 703, 705 and 707 may be used to undertake a health assessment for the following target groups:

Target Group	Frequency of Service
A Healthy Kids Check for children aged at least 3 years and less than 5 years of age, who have received or who are receiving their 4 year old immunisation	Once only to an eligible patient
A type 2 diabetes risk evaluation for people aged 40-49 years	Once every three years to an eligible

(inclusive) with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool	patient
A health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease	Once only to an eligible patient
A health assessment for people aged 75 years and older	Provided annually to an eligible patient
A comprehensive medical assessment for permanent residents of residential aged care facilities	Provided annually to an eligible patient
A health assessment for people with an intellectual disability	Provided annually to an eligible patient
A health assessment for refugees and other humanitarian entrants	Once only to an eligible patient

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

Health assessments are not available to people who are in-patients of a hospital or care recipients in a residential aged care facility (with the exception of a comprehensive medical assessment provided to a permanent resident of a residential aged care facility).

Before a health assessment is commenced, the patient (and/or his or her parent(s), carer or representative, as appropriate) must be given an explanation of the health assessment process and its likely benefits. The patient must be asked whether he or she consents to the health assessment being performed. In cases where the patient is not capable of giving consent, consent must be given by his or her parent(s), carer or representative. Consent to the health assessment must be noted in the patient's records.

A health assessment must include the following elements:

- (a) information collection, including taking a patient history and undertaking or arranging examinations and investigations as required;
- (b) making an overall assessment of the patient;
- (c) recommending appropriate interventions;
- (d) providing advice and information to the patient;
- (e) keeping a record of the health assessment, and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment; and
- (f) offering the patient's carer (if any, and if the medical practitioner considers it appropriate and the patient agrees) a copy of the report or extracts of the report relevant to the carer.

A health assessment may only be claimed by a medical practitioner (including a general practitioner but not including a specialist or consultant physician).

A health assessment should generally be undertaken by the patient's 'usual doctor'. For the purpose of the health assessment items, 'usual doctor' means the medical practitioner, or a medical practitioner working in

the medical practice, which has provided the majority of primary health care to the patient over the previous twelve months and/or will be providing the majority of care to the patient over the next twelve months.

A health assessment should not take the form of a health screening service.

Practice nurses and registered Aboriginal health workers may assist medical practitioners in performing the health assessment, in accordance with accepted medical practice and under the supervision of the medical practitioner. This may include activities associated with:

- (a) information collection; and
- (b) providing patients with information about recommended interventions at the direction of the medical practitioner.

All other components of the health assessment must include a personal attendance by a medical practitioner.

Medical practitioners should not conduct a separate consultation for another health-related issue in conjunction with a health assessment unless it is clinically necessary (ie. the patient has an acute problem that needs to be managed separately from the assessment). The only exceptions are:

- (a) a health assessment provided as a Healthy Kids Check, where a consultation associated with the four year old immunisation can be conducted on the same occasion; and
- (b) the comprehensive medical assessment, where, if this health assessment is undertaken during the course of a consultation for another purpose, the health assessment item and the relevant item for the other consultation may both be claimed.

Items 701, 703, 705 and 707 do not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the *Health Insurance Act 1973* has been granted to an Aboriginal Community Controlled Health Service or State/Territory Government health clinic, items 701, 703, 705 and 707 can be claimed for services provided by medical practitioners salaried by or contracted to, the Service or health clinic. All other requirements of the items must be met.

**A.26.. Health Assessment provided as a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool**

Items 701, 703, 705 and 707 may be used to undertake a type 2 diabetes risk evaluation for people aged 40-49 years (inclusive) with a high risk of developing type 2 diabetes, as determined by the Australian Type 2 Diabetes Risk Assessment Tool.

The aim of this health assessment is to review the factors underlying the 'high risk' score identified by the Australian Type 2 Diabetes Risk Assessment Tool to instigate early interventions, such as lifestyle modification programs, to assist with the prevention of type 2 diabetes.

The Australian Type 2 Diabetes Risk Assessment Tool has been developed to provide a basis for both health professionals and health consumers to assess the risk of type 2 diabetes. It consists of a short list of questions which, when completed, provides a guide to a patient's current level of risk of developing type 2 diabetes. The item scores and risk rating calculations in the tool have been developed using demographic,

lifestyle, anthropometric and biomedical data from the 2000 Australian Diabetes, Obesity and Lifestyle baseline survey and the AusDiab 2005 follow-up study. The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from <http://www.health.gov.au/preventionoftype2diabetes>

Clinical risk factors that the medical practitioner must consider when providing this health assessment include:

- (a) lifestyle, such as smoking, physical inactivity and poor nutrition;
- (b) biomedical risk factors, such as high blood pressure, impaired glucose metabolism and excess weight;
- (c) any relevant recent diagnostic test results; and
- (d) a family history of chronic disease.

The health assessment must include the following:

- (a) evaluating a patient's high risk score, as determined by the Australian Type 2 Diabetes Risk Assessment Tool which has been completed by the patient within a period of 3 months prior to undertaking the health assessment;
- (b) updating the patient's history and undertaking physical examinations and clinical investigations in accordance with relevant guidelines;
- (c) making an overall assessment of the patient's risk factors and of the results of relevant examinations and investigations;
- (d) initiating interventions, if appropriate, including referral to a lifestyle modification program and follow-up relating to the management of any risk factors identified (further information is available at <http://www.health.gov.au/preventionoftype2diabetes>); and
- (e) providing the patient with advice and information (such as the Lifescript resources produced by the Department of Health and Ageing), including strategies to achieve lifestyle and behaviour changes if appropriate (further information is available at <http://www.health.gov.au/lifescrpts>).

The completion of the Australian Type 2 Diabetes Risk Assessment Tool is mandatory for patient access to this health assessment. The tool can be completed either by the patient or with the assistance of a health professional or practice staff. Patients with a 'high' score result are eligible for the health assessment, and subsequent referral to the subsidised lifestyle modification programs if appropriate (further information is available at <http://www.health.gov.au/preventionoftype2diabetes>).

A health assessment for a type 2 diabetes risk evaluation for people aged 40-49 years with a high risk of developing type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool may only be claimed once every three years by an eligible patient.

#### **A.27.. Health Assessment provided for people aged 45-49 years who are at risk of developing chronic disease**

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people aged 45-49 years (inclusive) who are at risk of developing chronic disease.

For the purposes of this health assessment, a patient is at risk of developing a chronic disease if, in the clinical judgement of the attending medical practitioner, a specific risk factor for chronic disease is identified.

Risk factors that the medical practitioner can consider include, but are not limited to:

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

A chronic disease or condition is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular illness, diabetes mellitus, mental health conditions, arthritis and musculoskeletal conditions.

If, after receiving this health assessment, a patient is identified as having a high risk of type 2 diabetes as determined by the Australian Type 2 Diabetes Risk Assessment Tool, the medical practitioner may refer that person to a subsidised lifestyle modification program, along with other possible strategies to improve the health status of the patient (further information is available at <http://www.health.gov.au/preventionoftype2diabetes>).

The Australian Type 2 Diabetes Risk Assessment Tool can be obtained from <http://www.health.gov.au/preventionoftype2diabetes>

A health assessment for people aged 45-49 years who are at risk of developing chronic disease may only be claimed once by an eligible patient.

#### **A.28.. Health Assessment provided for people aged 75 years and older**

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people aged 75 years and older.

A health assessment for people aged 75 years and older is an assessment of a patient's health and physical, psychological and social function for the purpose of initiating preventive health care and/or medical interventions as appropriate.

This health assessment must include:

- (a) measurement of the patient's blood pressure, pulse rate and rhythm;
- (b) an assessment of the patient's medication;
- (c) an assessment of the patient's continence;
- (d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus;
- (e) an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months;
- (f) an assessment of the patient's psychological function, including the patient's cognition and mood; and

- (g) an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

A health assessment for people aged 75 years and older may be claimed once every twelve months by an eligible patient.

**A.29.. Health Assessment provided as a comprehensive medical assessment for residents of residential aged care facilities**

Items 701, 703, 705 and 707 may be used to undertake a comprehensive medical assessment of a resident of a residential aged care facility.

This health assessment requires assessment of the resident's health and physical and psychological function, and must include:

- (a) making a written summary of the comprehensive medical assessment;
- (b) developing a list of diagnoses and medical problems based on the medical history and examination;
- (c) providing a copy of the summary to the residential aged care facility; and
- (d) offering the resident a copy of the summary.

A residential aged care facility is a facility in which residential care services, as defined in the *Aged Care Act 1997*, are provided. This includes facilities that were formerly known as nursing homes and hostels. A person is a resident of a residential aged care facility if the person has been admitted as a permanent resident of that facility.

This health assessment is available to new residents on admission into a residential aged care facility. It is recommended that new residents should receive the health assessment as soon as possible after admission, preferably within six weeks following admission into a residential aged care facility.

A health assessment for the purpose of a comprehensive medical assessment of a resident of a residential aged care facility may be claimed by an eligible patient:

- (a) on admission to a residential aged care facility, provided that a comprehensive medical assessment has not already been provided in another residential aged care facility within the previous 12 months; and
- (b) at 12 month intervals thereafter.

**A.30.. Health Assessment provided for people with an intellectual disability**

Items 701, 703, 705 and 707 may be used to undertake a health assessment for people with an intellectual disability.

A person is considered to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient [IQ]) and would benefit from assistance with daily living activities. Where medical practitioners wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a

paediatrician registered to practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

The health assessment provides a structured clinical framework for medical practitioners to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventive health care required. The health assessment must include the following items as relevant to the patient or his or her representative:

- (a) Check dental health (including dentition);
- (b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);
- (c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);
- (d) Assess nutritional status (including weight and height measurements) and a review of growth and development;
- (e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);
- (f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);
  - Advise carers of the common side effects and interactions.
  - Consider the need for a formal medication review.
- (g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;
- (h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);
- (i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;
- (j) Consider the need for breast examination, mammography, Papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;
- (k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;
- (l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;
- (m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;
- (n) Check for thyroid disease at least every two years (or yearly for patients with Down syndrome);
- (o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;

- (p) Assess or review treatment for co-morbid mental health issues;
- (q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and
- (r) Consider whether there are any signs of physical, psychological or sexual abuse.

A health assessment for people with an intellectual disability may be claimed once every twelve months by an eligible patient.

**A.34.. A health assessment for an Aboriginal and Torres Strait Islander adult (aged between 15 years and 54 years)**

This health assessment involves all of the following:

- (a) a personal attendance by a medical practitioner;
- (b) taking the patient's medical history, including the following:
  - i. current health problems and risk factors;
  - ii. relevant family medical history;
  - iii. medication usage (including medication obtained without prescription or from other doctors);
  - iv. immunisation status, by reference to the appropriate current age and sex immunisation schedule;
  - v. sexual and reproductive health;
  - vi. physical activity, nutrition and alcohol, tobacco or other substance use;
  - vii. hearing loss;
  - viii. mood (including incidence of depression and risk of self-harm); and
  - ix. family relationships and whether the patient is a carer, or is cared for by another person.
- (c) examination of the patient, including the following:
  - i. measurement of the patient's blood pressure, pulse rate and rhythm;
  - ii. measurement of height and weight to calculate body mass index and, if indicated, measurement of waist circumference for central obesity;
  - iii. oral examination (including gums and dentition);
  - iv. ear and hearing examination (including otoscopy and, if indicated, a whisper test); and
  - v. urinalysis (by dipstick) for proteinuria.
- (d) undertaking or arranging any required investigation, considering the need for the following tests, in particular, (in accordance with national or regional guidelines or specific regional needs):
  - i. fasting blood sugar and lipids (by laboratory based test on venous sample) or, if necessary, random blood glucose levels;
  - ii. pap smear;

- iii. examination for sexually transmitted infection (by urine or endocervical swab for chlamydia and gonorrhoea, especially for those aged from 15 to 35 years); and
  - iv. mammography, if eligible (by scheduling appointments with visiting services or facilitating direct referral).
- (e) assessing the patient using the information gained in the adult health assessment; and
- (f) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

**A.35.. A health assessment for an Aboriginal and Torres Strait Islander older person (aged 55 years and over)**

This health assessment involves all of the following:

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

**A.36.. Chronic Disease Management Items (Items 721 to 732)**

<i>Description</i>	<i>Item No</i>	<i>Minimum claiming period*</i>
Preparation of a GP Management Plan (GPMP)	721	12 months
Coordination of Team Care Arrangements (TCAs)	723	12 months
Review of a GP Management Plan or Coordination of a Review of Team Care Arrangements	732	3 months

- CDM services may be provided more frequently in the exceptional circumstances defined below.

Exceptional circumstances exist for a patient if there has been a significant change in the patient’s clinical condition or care requirements that necessitates the performance of the service for the patient.

**Regulatory requirements**

Items 721, 723 and 732 provide fees for GPs to manage chronic conditions by preparing, coordinating, reviewing or contributing to chronic disease management (CDM) plans. They apply for a patient who suffers from at least one medical condition that has been present (or is likely to be present) for at least six months.

### **Patient eligibility**

In addition to the eligibility requirements listed in the individual CDM item descriptors, the General Medical Services Table (GMST) mandates the following eligibility criteria:

#### ***CDM items 721, 723 and 732***

These are:

- available to patients in the community; and
- not available to public in-patients of a hospital; or care recipients in a residential aged care facility.

#### **Item 721**

A comprehensive written plan must be prepared describing:

- (a) the patient's health care needs, health problems and relevant conditions;
- (b) management goals with which the patient agrees;
- (c) actions to be taken by the patient;
- (d) treatment and services the patient is likely to need;
- (e) arrangements for providing this treatment and these services;
- (f) suggestions to facilitate a return to work; and
- (g) arrangements to review the plan by a date specified in the plan.

In preparing the plan, the provider must:

- (a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in preparing the plan; and
- (b) record the plan; and
- (c) record the patient's agreement to the preparation of the plan; and
- (d) provide a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- (e) add a copy of the plan to the patient's medical records.

#### **Item 723**

When coordinating the development of Team Care Arrangements (TCAs), the medical practitioner must:

- (a) consult with at least two collaborating providers, each of whom will provide a different kind of treatment or service to the patient, and one of whom may be another medical practitioner, when making arrangements for the multidisciplinary care of the patient; and

- (b) prepare a document that describes:
  - i. treatment, service and return to work goals for the patient;
  - ii. treatment and services that collaborating providers will provide to the patient; and
  - iii. actions to be taken by the patient;
  - iv. arrangements to review (i), (ii) and (iii) by a date specified in the document; and
- (c) explain the steps involved in the development of the arrangements to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
- (d) discuss with the patient the collaborating providers who will contribute to the development of the TCAs and provide treatment and services to the patient under those arrangements; and
- (e) record the patient's agreement to the development of TCAs;
- (f) give copies of the relevant parts of the document to the collaborating providers;
- (g) give a copy of the document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
- (h) add a copy of the document to the patient's medical records.

One of the minimum two service providers collaborating with the GP can be another medical practitioner. The patient's informal or family carer, the claims agent, employer (including the employer's rehabilitation and return to work co-ordinator), and a workplace rehabilitation provider can be included in the collaborative process but does not count towards the minimum of three collaborating providers.

### **Item 732**

An "associated medical practitioner" is a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) who, if not engaged in the same general practice as the medical practitioner mentioned in that item, performs the service mentioned in the item at the request of the patient (or the patient's guardian).

When reviewing a GP Management Plan, the medical practitioner must:

- (a) explain to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees) the steps involved in the review;
- (b) record the patient's agreement to the review of the plan;
- (c) review all the matters set out in the relevant plan;
- (d) make any required amendments to the patient's plan;
- (e) give a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
- (f) provide a copy of the review of the GPMP to the medical practitioner if the service is conducted by an associated medical practitioner

- (g) add a copy of the amended document to the patient's records; and
- (h) provide for further review of the amended plan by a date specified in the plan.

When coordinating a review of Team Care Arrangements, the practitioner must:

- (i) explain 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. This can also include the claims agent, employer (including the employer's rehabilitation and return to work co-ordinator), and a workplace rehabilitation provider);
- (ii) record the patient's agreement to the review of the TCAs or plan;
- (iii) consult with at least two health or care providers (each of whom provides a service or treatment to the patient that is different from each other and different from the service or treatment provided by the medical practitioner who is coordinating the TCAs or plan) to review all the matters set out in the relevant plan;
- (iv) make any required amendments to the patient's plan;
- (v) give a copy of the amended document to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees);
- (vi) provide a copy of the review of the TCA to the medical practitioner if the service is conducted by another medical practitioner
- (vii) provide for further review of the amended plan by a date specified in the plan;
- (viii) give copies of the relevant parts of the amended plan to the collaborating providers; and
- (ix) add a copy of the amended document to the patient's records.

### ***Claiming of fees***

Each service to which item 732 applies (i.e. Review of a GP Management Plan and Review of Team Care Arrangements) may be claimed once in a three-month period, except where there are exceptional circumstances arising from a significant change in the patient's clinical condition or care circumstances that necessitates earlier performance of the service for the patient.

Where a service is provided in exceptional circumstances, the patient's invoice should be annotated to indicate the reason why the service was required earlier than the minimum time interval for the relevant item. Item 732 can be claimed twice on the same day providing an item 732 for reviewing a GP Management Plan and another 732 for reviewing Team Care Arrangements (TCAs) are both delivered on the same day as per the item descriptors and these guidelines.

### ***Requirements when item 732 is claimed twice on the same day***

If a GPMP and TCAs are both reviewed on the same date and item 732 is to be claimed twice on the same day, invoices need to indicate they were rendered at different times.

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

The GP Management Plan items (721 and 732) and the Team Care Arrangement items (723 and 732) can not be claimed by general practitioners when they are a recognised specialist in the specialty of palliative medicine and treating a referred palliative care patient under items 3005-3093. The referring practitioner is able to provide the CDM services.

### **Additional information**

Items 721-732 should generally be undertaken by the patient's **usual medical practitioner**. The patient's "usual GP" means the GP, or a GP working in the medical practice, who has provided the majority of care to the patient over the previous twelve months and/or will be providing the majority of GP services to the patient over the next twelve months. The term "usual GP" would not generally apply to a practice that provides only one specific CDM service.

### **A.39.. Public Health Medicine - (Items 410 to 417)**

Attendances by public health physicians will attract fees under the new items only where the attendance relates to one or more of the following: -

- (i) management of a patient's vaccination requirements for accepted immunisation programs; or
- (ii) prevention or management of sexually transmitted disease; or
- (iii) prevention or management of disease due to environmental hazards or poisons; or
- (iv) prevention or management of exotic diseases; or
- (v) prevention or management of infection during outbreaks of infectious disease.

*For more information on the content-based item structure used in this Group, see A.5 in these guidelines.*

### **A.41.. Medication Management Reviews - (Items 900 and 903)**

#### **Item 900 - Domiciliary Medication Management Review**

A Domiciliary Medication Management Review (DMMR) (Item 900), also known as Home Medicines Review, is intended to maximise an individual patient's benefit from their medication regimen, and prevent medication-related problems through a team approach, involving the patient's GP and preferred community pharmacy.

#### **Patient eligibility**

The item is available to people living in the community who meet the criteria for a DMMR.

The item is not available for in-patients of a hospital, or care recipients in residential aged care facilities.

DMMRs are targeted at patients who are likely to benefit from such a review: patients for whom quality use of medicines may be an issue or; patients who are at risk of medication misadventure because of factors such as their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or a lack of knowledge and skills to use medicines to their best effect.

Examples of risk factors known to predispose people to medication related adverse events are:

- currently taking five or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last three months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists; and
- recent discharge from a facility / hospital (in the last four weeks).

### **REGULATORY REQUIREMENTS**

In conducting a DMMR, a medical practitioner must:

- (a) assess a patient's medication management needs; and
- (b) following that assessment, refer the patient to a community pharmacy for a DMMR; and
- (c) with the patient's consent, provide relevant clinical information required for the review; and
- (d) discuss with the reviewing pharmacist the results of that review, including suggested medication management strategies; and
- (e) develop a written medication management plan following discussion with the patient.

### **Claiming**

A DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

The fee is not claimable until all the components of the item have been rendered.

Fees for a DMMR service under item 900 are payable only once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (e.g. diagnosis of a new condition or recent discharge from hospital involving significant changes in medication).

If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.

If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 may be claimed.

If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.

Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (e.g. because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant attendance items should be used.

### **FURTHER GUIDANCE**

A DMMR should generally be undertaken by the patient's usual medical practitioner. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will be providing the majority of services to the patient over the coming 12 months.

The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.

The process of **referral to a community pharmacy** includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a fee is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and
- Provision to the patient's preferred community pharmacy, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.
- A DMMR referral form is available for this purpose. If this form is not used, the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy.

The **discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist** includes:

- Receiving a written report from the reviewing pharmacist; and
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and
- Developing a summary of the relevant review findings as part of the draft medication management plan.

Development of **a written medication management plan following discussion with the patient** includes:

- Developing a draft medication management plan and discussing this with the patient; and
- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

### **Item 903 - Residential Medication Management Review**

A Residential Medication Management Review (RMMR) is a collaborative service available to permanent residents of a Residential Aged Care facility (RACF) who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or residents who are at risk of medication misadventure because of a significant change in their condition or medication regimen.

#### **Patient eligibility**

RMMRs are available to:

- new residents on admission into a RACF; and
- existing residents on an 'as required' basis, where in the opinion of the resident's medical practitioner, it is required because of a significant change in medical condition or medication regimen.

RMMRs are not available to people receiving respite care in a RACF. Domiciliary Medicines Reviews are available to these people when they are living in the community setting.

#### **REGULATORY REQUIREMENTS**

When conducting a RMMR, a GP must:

- (a) discuss the proposed review with the resident and seek the resident's consent to the review; and
- (b) collaborate with the reviewing pharmacist about the pharmacist's involvement in the review; and
- (c) if recommended changes to the resident's medication management arise out of the review, participate in a post-review discussion (either face-to-face or by telephone) with the pharmacist to discuss the outcomes of the review including:
  - (i) the findings; and
  - (ii) medication management strategies; and
  - (iii) means to ensure that the strategies are implemented and reviewed, including any issues for implementation and follow-up; and
  - (iv) develop or revise the resident's medication management plan after discussion with the reviewing pharmacist; and
  - (v) finalise the plan after discussion with the resident.

A medical practitioner's involvement in a residential medication management review also includes:

- (a) offering a copy of the medication management plan to the resident (or the resident's carer or representative if appropriate); and
- (b) providing copies of the plan for the resident's records and for the nursing staff of the residential aged care facility; and

(c) discussing the plan with nursing staff if necessary.

A post-review discussion is not required if:

- (a) there are no recommended changes to the resident's medication management arising out of the review; or
- (b) any changes are minor in nature and do not require immediate discussion; or

A RMMR comprises all activities to be undertaken by the medical practitioner from the time the resident is identified as potentially needing a medication management review up to the development of a written medication management plan for the resident.

### **Claiming**

A maximum of one RMMR rebate is payable for each resident in any 12 month period, except where there has been a significant change in the resident's medical condition or medication regimen requiring a new RMMR.

Fees are payable when all the activities of a RMMR have been completed. A RMMR service covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the resident:

- any immediate action required to be done at the time of completing the RMMR, based on and as a direct result of information gathered in the RMMR, should be treated as part of the RMMR item;
- any subsequent follow up should be treated as a separate consultation item;
- an additional consultation in conjunction with completing the RMMR should not be undertaken unless it is clinically indicated that a problem must be treated immediately.

In some cases a RMMR may not be able to be completed due to circumstances beyond the control of the medical practitioner (e.g. because the resident decides not to proceed with the RMMR or because of a change in the circumstances of the resident). In these cases the relevant MBS attendance item should be used in relation to any consultation undertaken with the resident.

If the consultation at which the RMMR is initiated, including discussion with resident and obtaining consent for the RMMR, is only for the purposes of initiating the review, only the RMMR item should be claimed.

If the RMMR is initiated during the course of a consultation undertaken for another purpose, the other consultation may be claimed as a separate service and the RMMR service would also apply.

If the medical practitioner determines that an RMMR is not necessary, the RMMR item does not apply. In this case, relevant consultation items should be used.

### **FURTHER GUIDANCE**

A RMMR should generally be undertaken by the resident's 'usual GP'. This is the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of care to the resident over the previous 12 months and/or will be providing the majority of care to the resident over the next 12 months.

GPs who provide services on a facility-wide contract basis, and/or who are registered to provide services to RACFs as part of aged care panel arrangements, may also undertake RMMRs for residents as part of their services.

Generally, new residents should receive an RMMR as soon as possible after admission. Where a resident has a Comprehensive Medical Assessment (CMA), the RMMR should be undertaken preferably after the results of the CMA are available to inform the RMMR.

A RMMR service should be completed within a reasonable timeframe. As a general guide, it is expected that most RMMR services would be completed within four weeks of being initiated.

The resident's medical practitioner may identify the potential need for an 'as required' RMMR for existing residents, including in the course of a consultation for another purpose. The potential need for an RMMR may also be identified by the reviewing pharmacist, supply pharmacist, Residential Aged Care Facility staff, the resident, the resident's carer or other members of the resident's health care team.

The medical practitioner should assess the clinical need for an RMMR from a quality use of medicines perspective with the resident as the focus, and initiate an RMMR if appropriate, in collaboration with the reviewing pharmacist.

The medical practitioner and reviewing pharmacist should agree on a preferred means for communicating issues and information relating to the provision of an RMMR service. This should include the method(s) of initiating the RMMR, exceptions to the post review discussion, and the preferred method of communication. This can be done on a facility basis rather than on a case-by-case basis.

Where the provision of RMMR services involves consultation with a resident it should be read as including consultation with the resident and/or their carer or representative where appropriate.

RMMRs do not count for the purposes of derived fee arrangements that apply to other consultations in a Residential Aged Care Facility.

**A.42.. Taking a Cervical Smear from a Woman who is Unscreened or Significantly Under-screened - (Items 2497 - 2509 and 2598 - 2616)**

The item numbers 2497, 2501, 2503, 2504, 2506, 2507, 2509, 2598, 2600, 2603, 2606, 2610, 2613 and 2616 should be used in place of the usual attendance item where as part of a consultation, a cervical smear is taken from a woman between the ages of 20 and 69 years inclusive who has not had a cervical smear in the last four years. These items should not be used in conjunction with item numbers 10994, 10995, 10998 or 10999 for Pap smears provided by practice nurses on behalf of a GP. Where a Pap smear is taken from an eligible patient by a practice nurse on behalf of a GP, the use of item 10995 or 10999 will initiate a Cervical Screening Service Incentive Payment (SIP) through the Practice Incentives Program (PIP).

The items apply only to women between the ages of 20 and 69 years inclusive who have a cervix, have had intercourse and have not had a cervical smear in the last four years.

When providing this service, the doctor must satisfy themselves that the woman has not had a cervical smear in the last four years by:

- asking the woman if she can remember having a cervical screen in the last four years; and

- checking their own practice's medical records.

If significant uncertainty still remains, the doctor may also contact his/her state cervical screening register.

Women from the following groups are more likely than the general population to be unscreened or significantly underscreened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older women.

Vault smears are not eligible for items 2497 - 2509 and 2598 - 2616.

**A.43.. Completion of the Annual Diabetes Cycle of Care for Patients with Established Diabetes Mellitus - (Items 2517 - 2526 and 2620 - 2635)**

The item numbers 2517, 2518, 2521, 2522, 2525, 2526, and 2620, 2622, 2624, 2631, 2633, 2635, should be used in place of the usual attendance item when a consultation completes the minimum requirements of the annual Diabetes Cycle of Care for a patient with established diabetes mellitus.

The annual Diabetes Cycle of Care must be completed over a period of 11 months and up to 13 months, and at a minimum must include:

Assess diabetes control by measuring HbA1c	At least once every year
Ensure that a comprehensive eye examination is carried out*	At least once every two years
Measure weight and height and calculate BMI**	At least twice every cycle of care
Measure blood pressure	At least twice every cycle of care
Examine feet***	At least twice every cycle of care
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Provide self-care education	Patient education regarding diabetes management
Review diet	Reinforce information about appropriate dietary choices
Review levels of physical activity	Reinforce information about appropriate levels of physical activity
Check smoking status	Encourage cessation of smoking (if relevant)
Review of Medication	Medication review

\* Not required if the patient is blind or does not have both eyes.

\*\* Initial visit: measure height and weight and calculate BMI as part of the initial assessment.  
Subsequent visits: measure weight.

\*\*\* Not required if the patient does not have both feet.

These requirements are generally based on the current general practice guidelines produced by Diabetes Australia and the Royal Australian College of General Practitioners (*Diabetes Management in General Practice*). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.

Use of these items certifies that the minimum requirements of the Diabetes Cycle of Care have been completed for a patient with established diabetes mellitus in accordance with the guidelines above.

These items should only be used once per cycle per patient of either A18 Subgroup 2 or A19 Subgroup 2. For example, if item 2517 is claimed for a patient then no other diabetes item in groups A18 or A19 can be used for this patient in the same cycle.

The requirements for claiming these items are the minimum needed to provide good care for a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

#### **A.44.. Completion of the Asthma Cycle of Care - (Items 2546 - 2559 and 2664 - 2677)**

The item numbers 2546, 2547, 2552, 2553, 2558, 2559 and 2664, 2666, 2668, 2673, 2675 and 2677 should be used in place of the usual attendance item when a consultation completes the minimum requirements of the Asthma Cycle of Care.

At a minimum the Asthma Cycle of Care must include:

- At least 2 asthma related consultations within 12 months for a patient with moderate to severe asthma (at least 1 of which (the review consultation) is a consultation that was planned at a previous consultation),
- Documented diagnosis and assessment of level of asthma control and severity of asthma,
- Review of the patient's use of and access to asthma-related medication and devices,
- Provision to the patient of a written asthma action plan (if the patient is unable to use a written asthma action plan discussion with the patient about an alternative method of providing an asthma action plan, and documentation of the discussion in the patient's medical records),
- Provision of asthma self-management education to the patient, and
- Review of the written or documented asthma action plan.

The Asthma Cycle of Care should be provided to a patient by one GP or in exceptional circumstances by another GP within the same practice. In most cases, this will be the patient's usual medical practitioner. Completion of the Asthma Cycle of Care does not preclude referral to a specialist, but a specialist consultation cannot be counted as one of the two visits.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient-held written asthma action plan.

These items will only be payable for the completion of one Asthma Cycle of Care for each eligible patient per 12 month period, unless a further Asthma Cycle of Care is clinically indicated by exceptional circumstances.

#### ***Assessment of Severity***

Generally, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

- Symptoms on most days, OR
- Use of preventer medication, OR
- Bronchodilator use at least 3 times per week, OR

- Hospital attendance or admission following an acute exacerbation of asthma.

Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used.

#### **A.45.. GP Mental Health Treatment Items - (Items 2702 to 2713)**

This note provides information on the GP Mental Health Treatment items 2702, 2710, 2712, 2713. It includes an overview of the items, patient and provider eligibility, what activities are involved in providing services rebated by these items, links to other items and additional claiming information.

##### **Overview**

The GP Mental Health Treatment items define services for which fees are payable where GPs undertake early intervention, assessment and management of patients with mental disorders. They include referral pathways for treatment by psychiatrists, clinical psychologists and other allied mental health workers. These items complement the mental health items for psychiatrists (items 296 - 299), clinical psychologists (items 80000 - 80020) and allied mental health providers (items 80100 – 80170).

The GP Mental Health Treatment items incorporate a model for best practice primary health treatment of patients with mental disorders, including patients with both chronic or non-chronic disorders, that comprises:

- assess and plan;
- provide and/or refer for appropriate treatment and services;
- review and ongoing management as required.

##### **Who can provide**

The GP Mental Health Treatment Plan, Review and Consultation items are available for use in general practice by medical practitioners, including general practitioners but excluding specialists or consultant physicians. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim these items.

##### **Training Requirements (item 2710)**

GPs providing mental health Treatment Plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to item 2710. For GPs who have not undertaken training, item 2702 is available. Item 2702 provides for a mental health Treatment Plan to be prepared by the GP, but at a lower rebate than for item 2710. It is strongly recommended that GPs providing mental health treatment have appropriate mental health training. GP organisations support the value of appropriate mental health training for GPs using these items.

##### **What patients are eligible - Mental Disorder**

These items are for patients with a mental disorder who would benefit from a structured approach to the management of their treatment needs. Mental disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities (Refer to the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version). Dementia, delirium, tobacco use disorder and

mental retardation are not regarded as mental disorders for the purposes of the GP Mental Health Treatment items.

These GP services are available to eligible patients in the community. GP Mental Health Treatment Plan and Review services can also be provided to private in-patients (including private in-patients who are residents of aged care facilities) being discharged from hospital. Where the GP who provides the GP Mental Health Treatment item is providing in-patient treatment the item is claimed as an in-hospital service. GPs are able to contribute to care plans for patients using item 729, Contribution to a Multidisciplinary Care Plan, and to care plans for residents of aged care facilities using item 731.

### **PREPARING A GP MENTAL HEALTH TREATMENT PLAN – (Item 2702 or 2710)**

#### **What is involved - Assess and Plan**

A rebate can be claimed once the GP has undertaken an assessment and prepared a GP Mental Health Treatment Plan by completing the steps from Assessment to the point where patients do not require a new plan after their initial plan has been prepared, and meeting the relevant requirements listed under 'Additional Claiming Information'. This item covers both the assessment and preparation of the GP Mental Health Treatment Plan. Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment and preparation of the GP Mental Health Treatment Plan or components thereof (subject to patient agreement).

#### **Assessment**

An assessment of a patient must include:

- recording the patient's agreement for the GP Mental Health Treatment Plan service;
- taking relevant history (biological, psychological, social) including the presenting complaint;
- conducting a mental state examination;
- assessing associated risk and any co-morbidity;
- making a diagnosis and/or formulation; and
- administering an outcome measurement tool, except where it is considered clinically inappropriate.

The assessment can be part of the same consultation in which the GP Mental Health Treatment Plan is developed, or can be undertaken in different visits. Where separate visits are undertaken for the purpose of assessing the patient and developing the GP Mental Health Treatment Plan, they are part of the GP Mental Health Treatment Plan service and are included in item 2710.

In order to facilitate ongoing patient focussed management, an outcome measurement tool should be utilised during the assessment and the review of the GP Mental Health Treatment Plan, except where it is considered clinically inappropriate. The choice of outcome measurement tools to be used is at the clinical discretion of the practitioner. GPs using such tools should be familiar with their appropriate clinical use, and if not, should seek appropriate education and training.

#### **Preparation of a GP Mental Health Treatment Plan**

In addition to assessment of the patient, preparation of a GP Mental Health Treatment Plan must include:

- discussing the assessment with the patient, including the mental health formulation and diagnosis or provisional diagnosis;
- identifying and discussing referral and treatment options with the patient, including appropriate support services;
- agreeing goals with the patient – what should be achieved by the treatment - and any actions the patient will take;
- provision of psycho-education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate at this stage;
- making arrangements for required referrals, treatment, appropriate support services, review and follow-up; and
- documenting this (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP Mental Health Treatment Plan.

Treatment options can include referral to a psychiatrist; referral to a clinical psychologist for psychological therapies, or to an appropriately trained GP or allied mental health professional for provision of focussed psychological strategy services; pharmacological treatments; and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

When referring patients GPs should provide similar information as per normal GP referral arrangements. This could include providing a copy of the patient's GP Mental Health Treatment Plan, where appropriate and with the patient's agreement. The necessary referrals should be made after the steps above have been addressed and the patient's GP Mental Health Treatment Plan has been completed. It should be noted that the patient's mental health treatment plan should be treated as a living document for updating as required. In particular, the plan can be updated at any time to incorporate relevant information, such as feedback or advice from other health professionals on the diagnosis or treatment of the patient.

On completion of a course of treatment, the service provider must provide a written report on the course of treatment to the GP. The number of services that the patient is being referred for is at the discretion of the referring practitioner (eg. GP).

Many patients will not require a new plan after their initial plan has been prepared. A new plan should not be prepared unless clinically required, and generally not within 12 months of a previous plan. Ongoing management can be provided through the GP Mental Health Treatment Consultation and standard consultation items, as required, and reviews of progress through the GP Mental Health Treatment Plan Review item. A fee for preparation of a GP Mental Health Treatment Plan will not be paid within 12 months of a previous claim for the patient for the same or another Mental Health Treatment Plan item or within three months following a claim for a review (item 2712), other than in exceptional circumstances.

### **REVIEWING A GP MENTAL HEALTH TREATMENT PLAN – (Item 2712)**

The review item is a key component for assessing and managing the patient's progress once a GP Mental Health Treatment Plan has been prepared, along with ongoing management through the GP Mental Health Treatment Consultation item and/or standard consultation items. A patient's GP Mental Health Treatment Plan should be reviewed at least once.

A fee can be claimed once the GP who prepared the patient's GP Mental Health Treatment Plan (or another GP in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP Mental Health Treatment Plan by completing the activities that must be included in a review and meeting the relevant requirements listed under 'Additional Claiming Information'. The review item can also be used where a psychiatrist has prepared a referred assessment and management plan (item 291), as if that patient had a GP Mental Health Treatment Plan. The review service must include a personal attendance by the GP with the patient.

The review must include:

- recording the patient's agreement for this service;
- a review of the patient's progress against the goals outlined in the GP Mental Health Treatment Plan;
- modification of the documented GP Mental Health Treatment Plan if required;
- checking, reinforcing and expanding education;
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided; and
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that in most cases there will be other consultations between the patient and the GP as part of ongoing management.

The recommended frequency for the review service, allowing for variation in patients' needs, is:

- an initial review, which should occur between four weeks to six months after the completion of a GP Mental Health Treatment Plan; and
- if required, a further review can occur three months after the first review.

In general, most patients should not require more than two reviews in a 12 month period, with ongoing management through the GP Mental Health Treatment Consultation and standard consultation items, as required.

A rebate will not be paid within three months of a previous claim for the same item or within four weeks following a claim for a GP Mental Health Treatment Plan item other than in exceptional circumstances.

### **GP MENTAL HEALTH TREATMENT CONSULTATION – (Item 2713)**

The GP Mental Health Treatment Consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental disorder, including for a patient being managed under a GP

Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental disorder. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP Mental Health Treatment Consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented);
- providing treatment, advice and/or referral for other services or treatment; and
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP Mental Health Treatment Consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for services by focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan or under a referred psychiatrist assessment and management plan (item 291).

Consultations associated with this item must be at least 20 minutes duration.

#### **ADDITIONAL CLAIMING INFORMATION**

Before proceeding with any GP Mental Health Treatment Plan or Review service the GP must ensure that:

- (a) the steps involved in providing the service are explained to the patient and (if appropriate and with the patient's permission) to the patient's carer; and
- (b) the patient's agreement to proceed is recorded.

Before completing any GP Mental Health Treatment Plan or Review service and claiming a fee for that service, the GP must offer the patient a copy of the treatment plan or reviewed treatment plan and add the document to the patient's records. This should include, subject to the patient's agreement, offering a copy to their carer, where appropriate. The GP may, with the permission of the patient, provide a copy of the GP Mental Health Treatment Plan, or relevant parts of the plan, to other providers involved in the patient's treatment.

The GP Mental Health Treatment Plan, Review and Consultation items cover the consultations at which the relevant items are undertaken, noting that:

- if a GP Mental Health Treatment item is undertaken or initiated during the course of a consultation for another purpose, the GP Mental Health Treatment Plan, Review or Consultation item and the relevant item for the other consultation may both be claimed;
- if a GP Mental Health Treatment Plan is developed over more than one consultation, and those consultations are for the purposes of developing the plan, only the GP Mental Health Treatment Plan item should be claimed; and
- if a consultation is for the purpose of a GP Mental Health Treatment Plan, Review or Consultation item, a separate and additional consultation should not be undertaken in conjunction with the mental health consultation, unless it is clinically indicated that a separate problem must be treated immediately.

A fee is not claimable and an account should not be rendered until all components of the relevant item have been provided.

All consultations conducted as part of the GP Mental Health Treatment items must be rendered by the GP and include a personal attendance with the patient. A specialist mental health nurse, other allied health practitioner or Aboriginal Health Worker with appropriate mental health qualifications and training may provide general assistance to GPs in provision of mental health care.

### **Exceptional circumstances**

There are minimum time intervals for payment of rebates for GP Mental Health Treatment items (as detailed above), with provision for claims to be made earlier than these minimum intervals in exceptional circumstances. 'Exceptional circumstances' apply where there has been a significant change in the patient's clinical condition or care circumstances that requires, for example:

- a new GP Mental Health Treatment Plan or a new Review, rather than amending the existing GP Mental Health Treatment Plan; or

### **A.46.. Provision of Focussed Psychological Strategies - (Items 2721 to 2727)**

Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focussed Psychological Strategies to a patient must be made either in the context of a 3 Step Mental Health Process (former items 2574, 2575, 2577, 2578 and 2704, 2705, 2707 and 2708), a GP Mental Health Care Plan or a Psychiatrist Assessment and Management Plan.

### **Minimum Requirements**

All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment for these items will be limited to medical practitioners who are registered with Medicare Australia as having satisfied the requirements for higher level mental health skills for provision of the service, as determined by the General Practice Mental Health Standards Collaboration.

Continued access to item numbers 2721 - 2727 will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

### ***Out-of-Surgery Consultation***

It is expected that this service would be provided only for patients who are unable to attend the practice.

### ***Specific Focussed Psychological Strategies***

A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

#### **1. Psycho-education** (including motivational interviewing)

**2. Cognitive-behavioural Therapy including:**

- Behavioural interventions
- Behaviour modification
- Exposure techniques
- Activity scheduling
- Cognitive interventions
- Cognitive therapy

**3. Relaxation strategies**

- Progressive muscle relaxation
- Controlled breathing

**4. Skills training**

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

**5. Interpersonal Therapy****Mental Disorder**

A mental disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder – this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD - 10 Chapter V Primary Health Care Version.

Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of these items.

**A.47.. Pain and Palliative Medicine (Items 2801 to 3093)**

Attendance by a recognised specialist or consultant physician in the specialty of pain medicine (2801, 2806, 2814, 2824, 2832, 2840) and Case conference by a recognised specialist or consultant physician in the specialty of pain medicine (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000).

Items 2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000, apply only to a service provided by a recognised specialist or consultant physician in the specialty of pain medicine, in relation to a pain patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

The conditions that apply to the Case Conferences items (2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of pain medicine and that service is pain medicine, then the relevant items from the pain specialist group (2801, 2806, 2814, 2824, 2832, 2840, 2946, 2949, 2954, 2958, 2972, 2974, 2978, 2984, 2988, 2992, 2996, 3000) must be claimed. Services to patients who are not receiving pain medicine services should be claimed using the relevant attendance or case conferencing items.

Attendance by a recognised specialist or consultant physician in the specialty of palliative medicine (3005, 3010, 3014, 3018, 3023, 3028) and Case conference by a recognised specialist or consultant physician in the specialty of palliative medicine (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093).

Items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093, apply only to a service provided by a recognised specialist or consultant physician in the specialty of palliative medicine, in relation to a palliative patient referred from another practitioner (see Paragraph 6 of the General Explanatory notes).

General Practitioners who are recognised specialist in the specialty of palliative medicine and are treating a referred palliative patient and claiming items 3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093 cannot access the GP Management Plan items (721 and 732) or Team Care Arrangement items (723 and 732) for that patient. The referring practitioner is able to provide these services.

The conditions that apply to the Case Conferences items (3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) are the same as those for the Case Conferences by consultant physicians (Items 820 to 838). See explanatory note A.25 for details of these conditions.

Where the service provided to a referred patient is by a medical practitioner who is a recognised specialist or consultant physician in the specialty of palliative medicine and that service is a palliative medicine service, then the relevant items from the palliative specialist group (3005, 3010, 3014, 3018, 3023, 3028, 3032, 3040, 3044, 3051, 3055, 3062, 3069, 3074, 3078, 3083, 3088, 3093) must be claimed. Services to patients who are not receiving palliative care services should be claimed using the relevant attendance or case conferencing items.

#### **A.48.. Telepsychiatry - (Items 353 to 370)**

**Telepsychiatry** is defined as electronic transmission of psychiatric consultations, advice or services in digital form from one location to another using a data communication link provided by a third party carrier, or carriers. It requires the providers to comply with the International Telecommunications Union Standards which cover all types of videoconferencing from massive bandwidth to internet use. If X-rays are required for a psychiatric consultation then the consultant psychiatrist must comply with the DICOM Standards.

### **Duration of Telepsychiatry Consultation**

For items 353 to 358 the **time** provides a range of options equal to those provided in items 300 to 308 to allow for the appropriate treatment depending on the requirements of the treatment plan.

### **Number of Consultations in a Calendar Year**

Items 353 to 358 may only be claimed for up to a maximum of 12 consultations in aggregate for each patient in a calendar year. Items 364 to 370 are to be claimed where face-to-face consultations are clinically indicated. Items 364 to 370 must be used to ensure that Medicare payments continue for further telepsychiatry consultations.

If the number of attendances in aggregate to which items 296 to 299, 300 to 308, 353 to 358 and 361 to 370 apply exceeds 50 for a single patient in any calendar year, any further attendances on that patient in that calendar year would be covered by items 310 to 318.

### **Documenting the Telepsychiatry Session**

For items 353 to 370 the psychiatrist must keep a record of the treatment provided during an episode of care via telepsychiatry sessions or face-to-face consultations and must convey this in writing to the referring medical practitioner after the first session and then, at a minimum, after every six consultations.

### **Geographical**

Telepsychiatry items 353 to 361 are available for use when a referred patient is located in a regional, rural or remote area. A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

### **Referral to Allied Mental Health Professionals (for new and continuing patients)**

#### **Referred Patient Assessment and Management Plan review (Item 359)**

Referral for item 359 should be through the GP for the management of patients with mental illness. In the event that a specialist of another discipline wishes to refer a patient for this item the referral should take place through the GP. Item 359 is available in instances where the GP initiates a review of the management plan provided under item 291, usually where the current plan is not achieving the anticipated outcome. It is expected that when a plan is reviewed, any modifications necessary will be made.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Referred Patient Assessment and Management Plan Guidelines` (Note: An electronic version of the Guidelines is available on the RANZCP website at [www.ranzcp.org](http://www.ranzcp.org) )

#### **Initial Consultations for NEW PATIENTS (Item 361)**

The rationale for item 361 is to improve access to psychiatric services by encouraging an increase in the number of new patients seen by each psychiatrist, while acknowledging that ongoing care of patients with severe mental illness is integral to the role of the psychiatrist. Referral for item 361 may be from a medical practitioner practising in general practice, a specialist or another consultant physician. It is intended that item 361 will apply once only for each new patient on the first occasion that the patient is seen by a

consultant psychiatrist. It is not generally intended that item 361 will be used in conjunction with, or prior to, item 291.

The use of items 361 and 296-299 by one consultant psychiatrist does not preclude them being used by another consultant psychiatrist for the same patient.

#### **A.49.. Attendances by Medical Practitioners who are Emergency Physicians - (Items 501 to 536)**

Items 501 to 536 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the ACEM.

Items 501 to 511 cover five categories of attendance based largely on the tasks undertaken in a recognised emergency medicine department of a private hospital by the practitioner during the attendance on the patient rather than simply on the time spent with the patient. The emergency department must be part of a hospital and this department must be licensed as an “emergency department” by the appropriate State government authority.

The attendances for items 501 to 515 are divided into five categories relating to the level of complexity, namely: Level 1; Level 2; Level 3; Level 4 and Level 5.

To assist medical practitioners who are emergency physicians in selecting the appropriate item number the following notes in respect of the various levels are given.

##### **LEVEL 1**

This item is for the obvious and straightforward cases and the practitioner’s records would reflect this. In this context “limited examination”, means examination of the affected part if required, and management of the action taken.

##### **LEVEL 2**

The description of this item introduces the words “expanded problem focussed history” and “formulation and documentation of a diagnosis and management plan in relation to one or more problems”. In this context an “expanded problem focussed history” means a history relating to a specific problem or condition; and “formulation and documentation of a management plan” includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels 1 and 2 relate not to time but to complexity.

##### **LEVEL 3**

Further levels of complexity are implied in these terms by the introduction of “medical decision making of moderate complexity”.

##### **LEVEL 4**

This item covers more difficult problems requiring the taking of a “detailed history” and “detailed examination of one or more systems”, with or without liaison with other health care professionals and subsequent discussion with the patient, his or her agent and/or relatives.

**LEVEL 5**

This item covers the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they are performed. These items also cover cases which need prolonged discussion. It involves the taking of a comprehensive history, comprehensive examination and involving medical decision making of high complexity.

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

**A.50.. Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition - (Items 519 to 536)**

The conditions to be met before services covered by items 519 to 536 attract fees are:

- (i) the patient must be in imminent danger of death ;
- (ii) the times relate to the total time spent with a single patient, even if the time spent by the physician is not continuous.

**A.54.. Neurosurgery Specialist Referred Consultation - (Items 6007 to 6015)**

Referred consultations provided by specialist neurosurgeons will be covered under items 6007 to 6015. These new items replace the use of specialist items 104 and 105 for referred consultations by neurosurgeons.

The neurosurgical consultation structure comprises an initial consultation (item 6007) and four categories of subsequent consultations (items 6009-6015). These categories relate to the time AND level of complexity of the attendance i.e

- (i) Level 1 - 6009
- (ii) Level 2 - 6011
- (iii) Level 3 - 6013
- (iv) Level 4 - 6015

The following provides further guidance for neurosurgeons in utilising the appropriate items in common clinical situations:

- (i) Initial consultation item 6007 will replace item 104.
- (ii) Subsequent consultation items 6009-6015 will replace item 105

Item 6009 (subsequent consultation on a patient for 15 mins or less) covers a minor subsequent attendance which is straightforward in nature. Some examples of a minor attendance would include consulting with the patient for the purpose of issuing a repeat script for anticonvulsant medications or the routine review of a patient with a ventriculo-peritoneal shunt.

Item 6011 (subsequent consultation on a patient for a duration of between 16 to 30 mins) would involve an detailed and comprehensive examination of the patient which is greater in complexity than would be provided under item 6009, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record included in the patient notes. Some examples of a detailed neurosurgical attendance would include:

- the reviewing of neuroimaging for the monitoring of a tumour or lesion and discussion of the results with the patient (e.g. meningiomaglioma, spinal cord tumour);
- consultation on a patient to review imaging for spinal cord/cauda equina/ nerve root compression from a disc prolapse and discussion of results; or
- consultation on a patient prior to insertion of a ventriculo-peritoneal shunt)

Item 6013 (subsequent consultation on a patient with complex neurological conditions for the duration of between 31 to 45 mins) should involve a extensive and comprehensive examination of the patient greater in complexity than under item 6011, arranging or evaluating any necessary investigations and include detailed relevant patient notes. Item 6013 would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is discussed in detail with the patient and a written record be included in the patient notes. Some examples of an extensive neurosurgical attendance would include:

- an attendance on a patient prior to a craniotomy for cerebral tumour;
- surgery for spinal tumour;
- revision of spinal surgery;
- epilepsy surgery; or
- for the treatment of cerebral aneurysm.

Examination of such patients would include full cranial nerve examination or examination of upper and lower limb nervous system.

Item 6015 (subsequent consultation on a patient with complex neurological conditions for a duration of more than 45 mins) should involve an exhaustive examination of the patient that is more comprehensive than 6013 and any ordering or evaluation of investigations and include detailed relevant patient notes. It would be expected to cover complications, adverse outcomes, or review of chronic conditions. Where a management plan is formulated it is expected that this plan is thoroughly discussed with the patient and a written record be included in the patient notes. An exhaustive neurosurgical consultation includes:

- managing adverse neurological outcomes;
- detailed discussion when multiple modalities are available for treatment (e.g. clipping versus coiling for management of a cerebral aneurysm, surgical resection versus radiosurgery for cerebral tumour); or

- discussion where surgical intervention is likely to result in a neurological deficit but surgery is critical to patient's life or to stop progressive neurologic decline (e.g. cranial nerve dysfunction, motor dysfunction secondary to a cerebral or spinal cord lesion).

Examination of such patients would include exhaustive neurosurgical examination including full neurological examination (cranial nerves and limbs) or detailed 'focused examination' (e.g.: brachial plexus examination)

Complex neurosurgical problems referred to in items 6013 and 6015 include:

- deterioration in neurologic function following cranial or spinal surgery;
- presentation with new neurologic signs/symptoms; multifocal spinal and cranial disease (e.g. neurofibromatosis); or
- chronic pain states following spinal surgery (including discussion of other treatment options and referral to pain management)

**NOTE:** It is expected that informed financial consent be obtained from the patient where possible.

#### **A.56.. Non-directive Pregnancy Support Counselling Service - (Item 4001)**

##### **Overview**

Where a pregnancy has been accepted as a compensable claim, WorkCover fees are to be paid for non-directive pregnancy support counselling services provided to women who are concerned about a current pregnancy, or a pregnancy that occurred in the preceding 12 months, by an eligible medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

Non-directive counselling is a form of counselling based on the understanding that, in many situations, people can resolve their own problems without being provided with a solution by the counsellor. The counsellor's role is to encourage the person to express their feelings but not suggest what decision the person should make. By listening and reflecting back what the person reveals to them, the counsellor helps them to explore and understand their feelings. With this understanding, the person is able to make the decision which is best for them.

The service involves the GP undertaking a safe, confidential process that helps the patient explore concerns they have about a current pregnancy or a pregnancy that occurred in the preceding 12 months. This includes providing, on request, unbiased, evidence-based information about all options and services available to the patient.

The service may be used to address any pregnancy related issues for which non-directive counselling is appropriate.

##### **Patient eligibility**

Fees for non-directive pregnancy support counselling services provided using item 4001 are available to women who are concerned about a current pregnancy or a pregnancy that occurred in the preceding 12 months.

Partners of eligible patients may attend each or any counselling session, however, only one fee applies to each service provided.

**WorkCover fees**

Fees are payable for up to three non-directive pregnancy support counselling services per patient, per pregnancy.

**Minimum Requirements**

This service may only be provided by a GP who has completed appropriate non-directive pregnancy counselling training.

**Category 8 – Miscellaneous Services****M.2.1. Services Provided By a Practice Nurse on Behalf of a Medical Practitioner - (Items 10993 to 10999)****Immunisation services provided by a practice nurse (item 10993)**

Item 10993 can only be claimed by a medical practitioner where an immunisation is provided to a patient by a practice nurse on behalf of the medical practitioner.

Item 10993 can be claimed only once per patient visit, even if more than one vaccine is administered during the same patient visit.

A practice nurse means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. The practice nurse must be appropriately qualified and trained to provide immunisations. This includes compliance with any state or territory requirements. For example, in some states and territories, some nurses can only administer a vaccine following an order or direction from a medical practitioner.

The medical practitioner under whose supervision the immunisation is provided retains responsibility for the health, safety and clinical outcomes of the patient.

Immunisation means the administration of a registered vaccine to a patient for any purpose other than as part of a mass immunisation of persons.

A registered vaccine means a vaccine that is included on the Australian Register of Therapeutic Goods. This includes all vaccines on the Australian Standard Vaccination Schedule and vaccines covered in the current edition of the Australian Immunisation Handbook. The following substances cannot be claimed under this item: vaccines used experimentally; homeopathic substances; immunotherapy for allergies (eg desensitisation preparations); and other substances that are not vaccines. There may also be state or territory limitations on the administration of some vaccines, such as those for tuberculosis, yellow fever and Q-fever.

All GPs whether vocationally registered or not are eligible to claim this item.

Where the medical practitioner also provides a service to the patient in addition to the immunisation being administered by the practice nurse, the medical practitioner is able to claim for the professional service they provide to the patient.

### **Wound management services provided by a practice nurse (item 10996)**

Item 10996 can only be claimed by a medical practitioner where wound management (other than normal aftercare) is provided to a patient by a practice nurse on behalf of the medical practitioner.

Item 10996 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

A practice nurse means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.

The practice nurse must be appropriately qualified and trained to treat wounds.

The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

The medical practitioner does not need to be present during the treatment of the wound. However, the medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.

Where a practice nurse provides ongoing wound management, the medical practitioner is not required to see the patient during each subsequent visit.

All GPs whether vocationally registered or not are eligible to claim this item.

Where the medical practitioner also provides a service to the patient in addition to the treatment by the practice nurse, the medical practitioner is able to claim for the professional service they provide to the patient.

### **Pap smear services and preventive checks provided by a practice nurse (item 10994, 10995, 10998 and 10999)**

Items 10994 and 10995 require taking of a Pap smear **and at least one** preventive check.

Item 10994 can be claimed by a medical practitioner where a Pap smear **and at least one** preventive check is taken by a practice nurse on behalf of the medical practitioner.

Item 10995 can be claimed by a medical practitioner where a Pap smear **and at least one** preventive check is taken by a practice nurse on behalf of the medical practitioner **and** the patient is a woman, between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.

Items 10994 and 10995 include a Pap smear and preventive checks associated with women's sexual and reproductive health, which would routinely be undertaken in conjunction with a Pap smear. A preventive check is a service which is reasonably necessary and appropriate for preventive care based on evidence of effectiveness and efficacy appropriate to the age of the patient.

#### **M.2.20 Services for items 10994 and 10995 must include a Pap smear and at least one preventive check from the following:**

- Checks for sexually transmitted infections (including chlamydia)

- Taking of a sexual and reproductive history
- Advice on contraception
- Breast awareness education
- Advice on post natal issues
- Continence advice and education;

and may also include:

- Smoking, Nutrition, Alcohol and Physical Activity (SNAP) behavioural risk factor assessment
- Blood pressure measurement.

General practices are referred to the Royal Australian College of General Practitioners' (RACGP) *Guidelines for preventive activities in general practice – 6<sup>th</sup> edition* (Red Book), the RACGP (2004) *SNAP guide: a population health guide to behavioural risk factors in general practice* and National Aboriginal Community Controlled Health Organisations (NACCHO) 2005 *National Guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples* for recommendations on appropriate checks for women in particular age ranges.

Where, in the course of discussion of sexual history and current sexual activity, a practice nurse becomes aware that one of the checks listed for another age group is appropriate, the practice nurse may include that check as part of the service provided.

Patients with symptoms should be referred to their GP for diagnosis and management.

Items 10994 and 10995 cannot be claimed together or in conjunction with items 10998, 10999, 2497-2509 or 2598-2616.

Items 10998 and 10999 apply to the taking of a Pap smear only.

Item 10998 can be claimed by a medical practitioner where a Pap smear is taken by a practice nurse on behalf of the medical practitioner.

Item 10999 can be claimed by a medical practitioner where a Pap smear is taken by a practice nurse on behalf of the medical practitioner **and** the Pap smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a Pap smear in the last 4 years.

Items 10998 and 10999 cannot be claimed in conjunction with each other or with items 10994, 10995, 2497-2509 or 2598 - 2616.

A practice nurse means a registered or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.

The practice nurse must be appropriately qualified and trained to take cervical smears and other preventive checks. This means that where credentialling arrangements are in place, the practice nurse should be credentialled as qualified and trained to take Pap smears. All practice nurses taking Pap smears and other preventive checks should have undertaken an accredited training course.

Continuing professional development is a compulsory part of the credentialling arrangements and is recommended for all nurses taking Pap smears and providing preventive checks in jurisdictions where there are currently no credentialling arrangements.

General practices, where nurses take Pap smears and provide preventive checks, should also have a written clinical risk management strategy covering issues like clinical roles, pathology follow-up and patient consent.

In all cases, the medical practitioner under whose supervision the Pap smear and preventive checks are provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the practice nurse is appropriately qualified and trained to perform Pap smears and other preventive checks. Medical practitioners are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

The supervising medical practitioner and practice nurse must also comply with any relevant legislative or regulatory requirements, including those applying to state and territory cervical cytology registers or laboratories and disease notification registers.

The medical practitioner is not required to be present while the Pap smear and preventive checks are undertaken. It is up to the medical practitioner to decide whether they need to see the patient. Where the medical practitioner has a consultation with the patient, then the medical practitioner is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice nurse is itemised separately under item 10994, 10995, 10998 or 10999 (as applicable) and should not be counted as part of the time spent with the medical practitioner.

All GPs whether vocationally registered or not are eligible to claim these items.

## Category 2 - Diagnostic Procedures and Investigations

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

Item 11003 covers an extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT).

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

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

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

For extended ambulatory or video EEG of at least 3 hours but not more than 24 hours duration, item 11004 should be claimed. However, where ambulatory or video EEG extends over several days, item 11004 covers recording on the first day and item 11005 for every day subsequent to the first.

Extended EEG recording of at least 3 hours duration, other than ambulatory or video recording, including Multiple Sleep Latency Testing (MSLT) is covered under item 11003.

#### **D.1.3. Neuromuscular Diagnosis - (Item 11012)**

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

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

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

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

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

#### **D.1.5. Electroretinography - (Items 11204, 11205, 11210 and 11211)**

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

#### **D.1.6. Computerised Perimetry Printed Results - (Items 11221 to 11225)**

Computerised perimetry performed by optometrists is covered by MBS items 10940 and 10941. Items 11221 - 11225 should not be used to repeat perimetry unless clinically necessary - such as where the results of the perimetry have been provided by the optometrist referring the patient to an ophthalmologist.

#### **D.1.7. Computerised Perimetry - (Items 11222 and 11225)**

Item 11222 for bilateral procedures cannot be claimed for patients who are totally blind in one eye. In this instance, item 11225 for unilateral procedures should be claimed, where appropriate.

These items relate to computerised perimetry (bilateral or unilateral) where a third or subsequent examination becomes necessary in a 12 month period. As indicated in the descriptions, these items apply only where a further examination is indicated in the presence of one of the following conditions:-

- established glaucoma where surgery may be required within a 6 month period and where there has been definite progression of damage over a 12 month period;
- established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or
- monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be disease such as glaucoma or neurological disease.

Claims in respect of Items 11222 and 11225 should be accompanied by clinical details confirming the presence of one of the above conditions.

**D.1.8. Multifocal Multichannel Objective Perimetry (MMOP) - (Items 11024, 11027, 11221, 11222, 11224 and 11225)**

WorkCover does not support MMOP at this time therefore fees are not payable for any MMOP procedures.

A restriction has been placed on the items 11024, 11027, 11221, 11222, 11224 and 11225 to exclude the use of MMOP and those items should not be claimed for MMOP.

**D.1.9. Orbital Contents - (Items 11240, 11241, 11242 and 11243)**

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

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

**D.1.10. Brain Stem Evoked Response Audiometry - (Item 11300)**

Item 11300 can be claimed for the programming of a cochlear speech processor.

**D.1.11. Electrocochleography - (Item 11304)**

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

**D.1.12. Non-determinate Audiometry - (Item 11306)**

This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11321 when not performed under the conditions set out in paragraph D1.13.

**D.1.13. Audiology Services - (Items 11309 to 11321)**

A medical service specified in Items 11309 to 11321 shall be taken to be a medical service for the purposes of payment if, and only if, it is rendered:

- (a) in conditions that allow the establishment of determinate thresholds;
- (b) in accordance with current WorkCover standards.

**D.1.14. Oto-Acoustic Emission Audiometry - (Item 11332)**

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

**D.1.15. Respiratory Function Tests - (Item 11503)**

The investigations listed hereunder would attract fees under Item 11503. This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

- (a) Carbon monoxide diffusing capacity by any method
- (b) Absolute lung volumes by any method
- (c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method
- (d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure

- (e) Measurement of airway or pulmonary resistance by any method
- (f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures
- (g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm
- (h) Measurement of the resistance of the anterior nares or pharynx
- (i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents, non-isotonic fluids or powder and post-bronchodilator spirometry
- (j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator
- (k) Tests of distribution of ventilation involving inhalation of inert gases
- (l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood
- (m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung
- (n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation, of at least 6 hours duration
- (o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia
- (p) Monitoring pulmonary arterial pressure at rest or during exercise
- (q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes
- (r) Measurement of the respiratory muscle endurance/fatigability by any technique
- (s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs
- (t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
- (u) Inhalation provocation testing to specific sensitising agents
- (v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator.

#### **D.1.16. Investigations of Venous Disease - (Items 11602, 11604 and 11605)**

These items relate to examinations performed in the investigation of venous disease and result from separating out the services previously claimed under item 11603 to better reflect current practice. The fees include components for interpretation of the results and provision of hard copy trace and report, the report

component of which must be performed by a medical practitioner. Doppler examinations without hard copy trace cannot be claimed as they are considered to be part of a consultation. Claiming of item 11602 is restricted to twice per patient per year.

Items 11602, 11604 and 11605 which are diagnostic items, should not be used in conjunction with sclerotherapy (echosclerotherapy).

In item 11604, photoplethysmography is specifically excluded from the range of plethysmography techniques which may be used in order for this item to be claimed.

In item 11605, infrared photoplethysmography is to be used, but only in complex cases, in order to assess venous function to determine surgical intervention or the conservative management of deep vein thrombosis.

#### **D.1.17. Investigation of Arterial Disease - (Items 11610, 11611 and 11614)**

These items relate to examinations performed in the investigation of arterial disease and result from separating out the services previously claimed under item 11603 to better reflect current practice. The fees include components for interpretation of the results and provision of hard copy trace or recording of waveforms and report, the report component of which must be performed by a medical practitioner.

#### **D.1.18. Twelve lead Electrocardiography - (Item 11700)**

Fees are precluded under this item unless a full 12-lead ECG is performed. Examinations involving less than twelve leads are regarded as part of the accompanying consultation. A 12-lead ECG refers to the recordings produced of 12 views of the heart by various combinations of placement of electrodes.

#### **D.1.19. Twelve lead Electrocardiography, Report Only - (Item 11701)**

This item provides a fee where tracings are referred to a medical practitioner for a report without an attendance on the patient by that practitioner. Where a patient is referred to a consultant for a consultation and takes ECG tracings with him/her, a separate fee is not payable for the consultant's interpretation of the tracings.

#### **D.1.20. Electrocardiographic (ECG) Recording of Ambulatory Patient - (Items 11708 and 11709)**

Fees are not payable for ambulatory blood pressure monitoring (under Item 11708 or 11709 or any other item). Likewise, where blood pressure monitoring and continuous ECG recording are undertaken conjointly on an ambulatory patient for 12 hours or more, fees are not payable for the blood pressure monitoring or for the continuous ECG recording under Item 11708 or 11709.

Items 11708 and 11709 require the continuous ECG recording of an ambulatory patient for twelve hours or more. Fees are only payable under these items if the ECG data is analysed and reported on by a specialist physician or consultant physician.

The changing of a tape or batteries is regarded as a continuation of the service and does not constitute a separate service for fee purposes. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode would be regarded as a separate service.

**D.1.21. Signal Averaged ECG Recording - (Item 11713)**

Fees are only payable under this item if the ECG data is analysed and reported on by a specialist physician or a consultant physician.

**D.1.22. Capsule Endoscopy to Investigate Obscure Gastrointestinal Bleeding - (Item 11820)**

Capsule endoscopy is primarily used to view the small bowel, which cannot be viewed by upper gastrointestinal endoscopy and colonoscopy. Item 11820 is limited to patients with obscure gastrointestinal bleeding, which can only be established when the cause of bleeding has not been identified by upper gastrointestinal endoscopy and colonoscopy. The item is limited to patients who have a history of gastrointestinal bleeding, and cannot be used for patients who are presenting with their first bleeding episode.

For fees to be payable under this item, capsule endoscopy must be provided within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy. Any bleeding after that time is considered to be a new episode. It is not expected that capsule endoscopy would be provided more than once in an episode of bleeding, or provided to the same patient on more than two occasions in a twelve month period.

For the purposes of Item 11820, specialists or consultant physicians performing this procedure must have endoscopic training recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

**D.1.23. Capsule Endoscopy to Conduct Small Bowel Surveillance (Item 11823)**

Fees are only payable for this item if:

- (a) the patient has been diagnosed with Peutz-Jeghers Syndrome;
- (b) the procedure 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
- (c) the procedure has not been performed in the preceding two-year period.

***Conjoint committee***

For the purposes of Item 11823, specialists or consultant physicians performing this procedure must have endoscopic training recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy.

**D.1.24. Epicutaneous Patch Testing - (Items 12012, 12015 and 12018)**

A standard epicutaneous patch test battery refers to the European Standard Series or the International Contact Research Group Standard Series.

**D.1.25. Administration of Thyrotropin Alfa-rch for the Detection of Recurrent Well-differentiated Thyroid Cancer - (Item 12201)**

Thyrotropin alfa-rch is a diagnostic agent that allows patients to remain on thyroid hormone therapy while being assessed for recurrent cancer. This item was introduced following an assessment by the Medical

Services Advisory Committee (MSAC) of the available evidence relating to the safety, effectiveness and cost-effectiveness of thyrotropin alfa-rch. MSAC found that the use of thyrotropin alfa-rch is associated with a lower diagnostic accuracy than when the patient has withdrawn from thyroid hormone therapy. Accordingly, fees are payable under the item only for patients in whom thyroid hormone therapy withdrawal is medically contraindicated and where concurrent whole body study using radioactive iodine and serum thyroglobulin are undertaken. Services provided to patients who do not demonstrate the indications set out in item 12201 do not attract fees under the item.

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

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

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

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

#### **D.1.26. Investigations for Sleep Apnoea - (Items 12203, 12207, 12210, 12213, 12215, 12217 and 12250)**

A “qualified adult sleep medicine practitioner” as described in Items 12203, 12207 and 12250, a “qualified paediatric sleep medicine practitioner” as described in Items 12210 and 12213 and a “qualified sleep medicine practitioner” as described in Items 12215 and 12217 means:

For practitioners who commenced providing sleep studies **before 1 March 1999**:

- (a) the person has been assessed by the Credentialling Subcommittee or the Appeal Committee of the Specialist Advisory Committee in Respiratory and Sleep Medicine of the Royal Australasian College of Physicians as having had, before 1 March 1999, sufficient training and experience in the relevant field of sleep medicine (that is, either adult or paediatric sleep medicine, for which there are separate items) to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies; or
- (b) the person has been assessed by the Credentialling Subcommittee or the Appeal Committee as having had, before 1 March 1999, substantial training or experience in either adult or paediatric sleep medicine (for which further specified training or experience in sleep medicine to be competent in independent

clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies, and either:

- (i) the period of 2 years immediately following that assessment has not expired; or
- (ii) the person has been assessed by the Credentialing Subcommittee as having satisfactorily finished the further training or gained the further experience specified for that person; OR

For practitioners who commenced providing sleep studies on or after **1 March 1999**:

- (c) the person has attained Level I or Level II of the relevant Advanced Training Program (in Adult or Paediatric Sleep Medicine) of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association, after having completed at least 12 months core training, including clinical practice in the relevant field of sleep medicine and in reporting sleep studies; or
- (d) the Specialist Advisory Committee in Respiratory and Sleep Medicine of the Royal Australasian College of Physicians has recognised the person, in writing, as having training equivalent to the training mentioned in paragraph (c).

In relation to paragraph (d) of items 12203 to 12217, and paragraph (b) of item 12250, the patient should be seen in consultation by a qualified sleep medicine practitioner to determine the necessity for the investigation, unless the necessity has been clearly established by other means.

Item 12207 relates to overnight investigation of sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period where all of the following conditions apply:-

- the patient has severe cardio-respiratory failure; **and**
- previous studies have demonstrated failure of continuous positive airway pressure or oxygen; **and**
- the study is for the adjustment and/or testing of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure)

Items 12215 and 12217 relate to overnight investigation for sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period when therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required.

Claims for fees in respect of items 12207, 12215 and 12217 should be accompanied by clinical details confirming the presence of the conditions set out above.

#### **D.1.27. Bone Densitometry - (Items 12306 to 12323)**

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

An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at either forearms or both heels or in combination is excluded for the purpose of WorkCover.

### *Referrals*

Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items 12306, 12309, 12312, 12315, 12318, 12321 and 12323.

For Items 12306 and 12309 the referral should specify the indication for the test, namely:

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

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

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

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

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

For Item 12318 the referral should specify the indication for the test, namely:

- (a) prolonged glucocorticoid therapy;
- (b) conditions associated with excess glucocorticoid secretion;
- (c) male hypogonadism;
- (d) female hypogonadism lasting more than 6 months before the age of 45;
- (e) primary hyperparathyroidism;
- (f) chronic liver disease;
- (g) chronic renal disease;
- (h) proven malabsorptive disorders;
- (i) rheumatoid arthritis; or
- (j) conditions associated with thyroxine excess.

*Definitions*

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

For Items 12312 and 12318

- (a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or
- (b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day; for a period anticipated to last for at least 4 months.

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

For Items 12312 and 12318

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

For Items 12315 and 12318

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

- (a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
- (b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or
- (c) histologically proven Coeliac disease.

## Category 3 - Therapeutic Procedures

### T.1.1. Hyperbaric Oxygen Therapy - (Items 13015, 13020, 13025 and 13030)

Hyperbaric Oxygen Therapy not covered by these items would attract fees on an attendance basis. For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

- (a) is equipped and staffed so that it is capable of providing to a patient:
  - hyperbaric oxygen therapy at a treatment pressure of at least 2.8 atmospheric pressure absolute (180 kilo pascal gauge pressure); and
  - mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment.

(b) is supported by:

- at least one specialist with training in Diving and Hyperbaric Medicine, or medical practitioner who holds the Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society who is rostered and immediately available to the facility during normal working hours;

(c) and is staffed by:

- a registered medical practitioner with training in Diving and Hyperbaric Medicine who is present in the hyperbaric facility and immediately available at all times when patients are undergoing treatment; and
- a registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Oxygen Facility Industry Guidelines (Draft Australian Standard SF346) who is present during hyperbaric oxygen therapy.

(d) has defined admission and discharge policies.

Item 13015 provides coverage for hyperbaric oxygen treatment of soft tissue radiation injury and radio necrosis, and hypoxic problem wounds in non-diabetic patients.

#### **T.1.2. Haemodialysis - (Items 13100 and 13103)**

Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

#### **T.1.3. Consultant Physician Supervision of Home Dialysis - (Item 13104)**

Item 13104 covers the planning and management of dialysis and the supervision of a patient on home dialysis by a consultant physician in the practice of his or her speciality of renal medicine. Planning and management would cover the consultant physician participating in patient management discussions coordinated by renal centres. Supervision of the patient at home can be undertaken by telephone or other electronic medium, and includes:

- Regular ordering, performance and interpretation of appropriate biochemical and haematological studies (generally monthly);
- Feed-back of results to the home patient and his or her treating general physician;
- Adjustments to medications and dialysis therapies based upon these results;
- Co-ordination of regular investigations required to keep patient on active transplantation lists, where relevant;
- Referral to, and communication with, other specialists involved in the care of the patient; and
- Being available to advise the patient or the patient's agent.

A record of the services provided should be made in the patient's clinical notes.

The schedule fee equates to one hour of time spent undertaking these activities. It is expected that the item will be claimed once per month, to a maximum of 12 claims per year. The patient should be informed that he or she will incur a charge for which a fee will be payable.

This item includes dialysis conducted in a residential aged care facility. In remote areas, where a patient's home is an unsuitable environment for home dialysis due to a lack of space, or the absence of telecommunication, electricity and water utilities, the item includes dialysis in a community facility such as the local primary health care clinic.

#### **T.1.4. Assisted Reproductive Technology ART Services - (Items 13200 to 13221)**

From 1 January 2010, the items for ART services, including In-Vitro Fertilisation (IVF), have been restructured in consultation with the ART profession and the patient group ACCESS. The new structure better reflects current clinical practice and will help to spread the cost of EMSN caps across the treatment cycle. There are no restrictions on the number of cycles that patients can have nor are there any age restrictions for these items.

The new structure includes two new items (13201 and 13202) and a number of amended items. Item 13200 has been amended and will provide for an **initial** treatment cycle in a single calendar year. New item 13201 has been introduced for a **subsequent** treatment cycle in association with items 13200 and 13202. New item 13202 covers an incomplete stimulated cycle, and can be billed as an initial treatment cycle in a single calendar year.

Embryology laboratory services covered by Items 13200, 13201 and 13206 have been amended to include the preparation of sperm together with egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing.

Items 13200, 13201, 13202, 13206, 13215 and 13218, do not include services provided in relation to artificial insemination.

Item 13221 has been amended to exclude sperm preparation for assisted reproductive technology using IVF. This item now provides for the preparation of sperm for the purpose of artificial insemination and can only be rendered in conjunction with item 13203.

Fees are not payable in respect of ANY other item in WorkCover's Medical Fee Schedule (including Pathology and Diagnostic Imaging) in lieu of or in conjunction with items 13200 – 13221 but excluding item 13202. Specifically, fees are not payable for these items in association with items 104, 105, 14203, 14206, 35637, pathology tests or diagnostic imaging.

A treatment cycle that is a series of treatments for the purposes of ART services is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending not more than 30 days later.

The date of service in respect of treatment covered by Items 13200, 13201, 13203, 13206, 13209 and 13218 is **DEEMED** to be the **FIRST DAY** of the treatment cycle.

Items 13200, 13201, 13202 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements.

**NOTE:** Items 14203 and 14206 are not payable for artificial insemination.

#### **T.1.5. Intracytoplasmic Sperm Injection - (Item 13251)**

Item 13251 provides for intracytoplasmic sperm injection for male factor infertility under the following circumstances:

- where fertilisation with standard IVF is highly unlikely to be successful; or
- where in a previous cycle of IVF, the fertilisation rate has failed due to low or no fertilisation.

Item 13251 excludes a service to which item 13218 applies. Sperm retrieval procedures associated with intracytoplasmic sperm injection are covered under items 37605 and 37606.

Items 13251, 37605, 37606 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

#### **T.1.6. Administration of Blood or Bone Marrow already Collected (Item 13706)**

Item 13706 is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

#### **T.1.7. Collection of Blood - (Item 13709)**

Fees are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.

Fees are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

#### **T.1.8. Intensive Care Units - (Items 13870 to 13888)**

'Intensive Care Unit' means a separate hospital area that:

- (a) is equipped and staffed so as to be capable of providing to a patient:
  - (i) mechanical ventilation for a period of several days; and
  - (ii) invasive cardiovascular monitoring; and
- (b) is supported by:
  - (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and
  - (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
  - (iii) a registered nurse for at least 18 hours in each day; and
- (c) has defined admission and discharge policies.

"**immediately available**" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day.

"**exclusively rostered**" means that the specialist's sole clinical commitment is to intensive care associated activities and is not involved in any other duties that may preclude immediate availability to intensive care if required.

For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that:

- (a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:
  - (i) mechanical ventilation for a period of several days; and
  - (ii) invasive cardiovascular monitoring; and
- (b) is supported by:
  - (i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and
  - (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
  - (iii) a registered nurse for at least 18 hours in each day; and
- (c) has defined admission and discharge policies.

Fees are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, fees are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract fees in addition to the intensive care items.

In respect of Neonatal Intensive Care Units, as defined above, fees are payable for admissions of babies who meet the following criteria:-

- (i) all babies weighing less than 1000gms;
- (ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;
- (iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;
- (iv) all babies requiring more than 40% oxygen for more than 4 hours;
- (v) all babies requiring an arterial line for blood gas or pressure monitoring; or
- (vi) all babies having frequent seizures.

Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge

policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For fee purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for fees under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888.

Likewise, fees are not payable under items 13870, 13873, 13876, 13881, 13882, 13885 and 13888 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

Fees are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

#### **T.1.9. Procedures Associated with Intensive Care - (Items 13818, 13842, 13847, 13848 and 13857)**

Item 13818 covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Fees are payable under this item only once per day except where a second discrete operation is performed on that day.

Fees are payable under items 13876 (within an ICU) and 11600 (outside an ICU) once only for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of the practitioners involved in monitoring the pressures.

If a service covered by Item 13842 is provided outside of an ICU, in association with, for example, an anaesthetic, fees are payable for Item 13842 in addition to Item 13870 where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item 13842.

#### ***Items 13847 and 13848***

Item 13847 covers management of counterpulsation by intraaortic balloon on the first day and includes initial and subsequent consultations and monitoring of parameters. Insertion of the intraaortic balloon is covered under item 38609 Management on each day subsequent to the first is covered under item 13848.

"management" of counterpulsation of intraaortic balloon means full haemodynamic assessment and management on several occasions during the day.

Item 13857 covers the establishment of airway access and initiation of ventilation on a patient outside intensive care for the purpose of subsequent ventilatory support in intensive care. Fees are not payable under Item 13857 where airway access and ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.

Fees are not payable for sampling by arterial puncture under Item 13839 in addition to Item 13870 (and 13873) on the same day. Fees are payable under Item 13842 (Intra-arterial cannulation) in addition to Item 13870 (and 13873) when performed on the same day.

#### **T.1.10. Management and Procedures in Intensive Care Unit - (Items 13870, 13873, 13876)**

Fees are only payable for management and procedures in intensive care covered by items 13870, 13873, 13876, 13882, 13885 and 13888 where the service is provided by a specialist or consultant physician who is immediately available and exclusively rostered for intensive care.

**Items 13870 and 13873**

Items 13870 and 13873 represent global daily fees covering all attendances by the intensivist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling and, bladder catheterisation performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

Items 13870 and 13873 should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

**Item 13876**

Item 13876 covers the monitoring of pressures in an ICU. Fees are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.

**Item 11600**

Item 11600 covers the monitoring of pressures outside the ICU by practitioners not associated with the ICU. Fees are paid only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day and irrespective of the number of practitioners involved in monitoring the pressures.

**T.1.11. Cytotoxic Chemotherapy Administration - (Item 13915)**

Following a recommendation of a National Health and Medical Research Council review committee in 2005, fees are no longer payable for professional services rendered for the purpose of administering microwave (UHF radiowave) cancer therapy, including the intravenous injection of drugs used in the therapy.

**T.1.12. Implanted Pump or Reservoir/Drug Delivery Device - (Items 13939 and 13942)**

The schedule fee for Items 13939 and 13942 includes a component to cover accessing of the drug delivery device. Accordingly, fees are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Items 13939 and 13942.

**T.1.13. PUVA or UVB Therapy - (Items 14050 and 14053)**

A component for any necessary subsequent consultation has been included in the Schedule fee for these items. However, the initial consultation preceding commencement of a course of therapy would attract fees.

**T.1.14. Laser Photocoagulation - (Items 14106 to 14124)**

The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items 14106 - 14124:

Entire forehead	50 -75 cm <sup>2</sup>
Cheek	55 - 85 cm <sup>2</sup>
Nose	10 -25 cm <sup>2</sup>

Chin	10 - 30 cm <sup>2</sup>
Unilateral midline anterior - posterior neck	60 - 220 cm <sup>2</sup>
Dorsum of hand	25 - 80 cm <sup>2</sup>
Forearm	100 - 250 cm <sup>2</sup>
Upper arm	105 - 320 cm <sup>2</sup>

**T.1.15. Laser Photocoagulation (Item 14124)**

Item 14124 applies where additional treatments are indicated in a 12 month period and are only claimable for haemangiomas of infancy.

**T.1.16. Hormone and Living Tissue Implantation - (Items 14203 and 14206)**

Items 14203 and 14206 are not payable for artificial insemination.

**T.1.17. Implantable Drug Delivery System for the Treatment of Severe Chronic Spasticity - (Items 14227 to 14242)**

Baclofen is provided under Section 100 of the Pharmaceutical Benefits Scheme for the following indications: Severe chronic spasticity, where oral agents have failed or have caused unacceptable side effects, in patients with chronic spasticity:

- (a) of cerebral origin; or
- (b) due to multiple sclerosis; or
- (c) due to spinal cord injury; or
- (d) due to spinal cord disease.

Items 14227 to 14242 should be used in accordance with these restrictions.

**T.1.18. Immunomodulating Agent - (Item 14245)**

Item 14245 applies only to a service provided by a medical practitioner who is registered in Australia for the purpose of providing an adequate pharmaceutical service for persons requiring treatment with an immunomodulating agent.

These drugs are associated with risk of anaphylaxis which must be treated by a medical practitioner. For this reason a medical practitioner needs to be available at all times during the infusion in case of an emergency.

**T.2.1. Radiation Oncology - General**

The level of payment for radiotherapy depends on the number of fields irradiated and the number of times treatment is given.

Treatment by rotational therapy (including rotational therapy using volumetric modulated arc therapy or intensity modulated arc therapy) is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract fees under Item 15100 plus twice Item 15103. Similarly, each attendance for arc therapy of the prostate using a dual photon linear accelerator

would attract fees under 15248 plus twice 15263. Fees are payable once only per attendance for treatment irrespective of whether one or more arcs are involved.

Fees for consultations rendered on the same day as treatment and/or planning services are only payable where they are clinically relevant. A clinically relevant service is one that is generally accepted by the relevant profession as being necessary for the appropriate treatment of the patient.

#### **T.2.2. Brachytherapy of the Prostate - (Item 15338)**

Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

**NOTE:** An approved site is one at which radiation oncology services may be performed lawfully under the law of the State or Territory in which the site is located.

#### **T.2.3. Intravascular Brachytherapy for Coronary Artery Restenoses - (Items 15360, 15363 AND 15541)**

These items were introduced into the Schedule on an interim basis, following a recommendation from the Medical Services Advisory Committee (MSAC). Interim funding is provided, pending further assessment of the long-term safety, efficacy and cost-effectiveness of the procedure, and the impact of emerging technologies such as drug-eluting stents.

#### **T.2.4. Planning Services - (Items 15500 to 15562 and 15850)**

A planning episode involves field setting and dosimetry. One plan only will attract fees in a course of treatment. However, fees are payable for a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

- further planning items where planning is undertaken in respect of a different tumour site to that (or those) specified in the original prescription by the radiation oncologist; and
- a plan for brachytherapy and a plan for megavoltage or teletherapy treatment, when rendered in the same course of treatment.

Items 15500 to 15533 (inclusive) are for a planning episode for 2D conformal radiotherapy. Items 15550 to 15562 (inclusive) are for a planning episode for 3D conformal radiotherapy.

It is expected that the 2D simulation items (15500, 15503, and 15506) would be used in association with the 2D planning items (15518, 15521, and 15524) in a planning episode. However there may be instances where it may be appropriate to use the 3D Planning items (15556, 15559, and 15562) in association with the 2D simulation items (15500, 15503, and 15506) in a planning episode. The 3D simulation items (15550 and 15553) can only be billed in association with the 3D planning items (15556, 15559, and 15562) in a planning episode.

Item 15850 covers radiation source localisation for high dose brachytherapy treatment. Item 15850 applies to brachytherapy provided to any part of the body.

#### **T.2.5. Treatment Verification - (Items 15700 to 15705, 15710 and 15800)**

In these items, 'treatment verification' means: a quality assurance procedure designed to facilitate accurate and reproducible delivery of the radiotherapy/brachytherapy to the prescribed site(s) or region(s) of the body as defined in the treatment prescription and/or associated dose plan(s) and which utilises the capture and assessment of appropriate images using:

- (a) x-rays (this includes portal imaging, either megavoltage or kilovoltage, using a linear accelerator)
- (b) computed tomography; or
- (c) ultrasound, where the ultrasound equipment is capable of producing images in at least three dimensions (unidimensional ultrasound is not covered);

together with a record of the assessment(s) and any correction(s) of significant treatment delivery inaccuracies detected.

Item 15700 covers the acquisition of images in one plane and incorporates both single or double exposures. The item may be itemised once only per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Item 15705 (multiple projections) applies where images in more than one plane are taken, for example orthogonal views to confirm the isocentre. It can be itemised only where verification is undertaken of treatments involving three or more fields. It can be itemised where single projections are acquired for multiple sites, eg multiple metastases for palliative patients. Item 15705 can be itemised only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

15710 applies to volumetric verification imaging using acquisition by computed tomography. It can be itemised only where verification is undertaken of treatments involving three or more fields and only once per attendance for treatment, irrespective of the number of treatment sites verified at that attendance.

Items 15700, 15705 and 15710:

- may not be claimed together for the same attendance at which treatment is rendered
- must only be itemised when the verification procedure has been prescribed in the treatment plan and the image has been reviewed by a radiation oncologist

Item 15800 – fees are payable once only per attendance at which treatment is verified.

### **T.3.1. Therapeutic Dose of Yttrium 90 - (Item 16003)**

This item cannot be claimed for selective internal radiation therapy (SIRT).

See items 35404, 35406 and 35408 for SIRT using SIR\_Spheres (yttrium-90 microspheres).

### **T.4.1. Antenatal Service Provided by a Nurse, Midwife or a Registered Aboriginal Health Worker - (Item 16400)**

Item 16400 can only be claimed by a medical practitioner (including a vocationally registered or non-vocationally registered GP, a specialist or a consultant physician) where an antenatal service is provided to a patient by a midwife, nurse or registered Aboriginal Health Worker on behalf of the medical practitioner at, or from an eligible practice location in a regional, rural or remote area.

A regional, rural or remote area is classified as a RRMA 3-7 area under the Rural Remote Metropolitan Areas classification system.

Evidence based national or regional guidelines should be used in the delivery of this antenatal service.

A midwife means a registered midwife who holds a current practising certificate as a midwife issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice.

A nurse means a registered or enrolled nurse who holds a current practising certificate as a nurse issued by a State or Territory regulatory authority and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice. The nurse must have appropriate training and skills to provide an antenatal service.

A registered Aboriginal Health Worker means an Aboriginal Health Worker who holds current registration issued by a State or Territory regulatory authority; and who is employed by, or whose services are otherwise retained by, the medical practitioner or their practice.

The midwife, nurse or registered Aboriginal Health Worker must also comply with any relevant legislative or regulatory requirements regarding the provision of the antenatal service.

The medical practitioner under whose supervision the antenatal service is provided retains responsibility for the health, safety and clinical outcomes of the patient. The medical practitioner must be satisfied that the midwife, nurse or registered Aboriginal Health Worker is appropriately registered, qualified and trained, and covered by indemnity insurance to undertake antenatal services.

Supervision at a distance is recognised as an acceptable form of supervision. This means that the medical practitioner does not have to be physically present at the time the service is provided. However, the medical practitioner should be able to be contacted if required.

The medical practitioner is not required to see the patient or to be present while the antenatal service is being provided by the midwife, nurse or registered Aboriginal Health Worker. It is up to the medical practitioner to decide whether they need to see the patient. Where a consultation with the medical practitioner has taken place prior to or following the antenatal service, the medical practitioner is entitled to claim for their own professional service, but item 16400 cannot be claimed in these circumstances.

Item 16400 cannot be claimed in conjunction with another antenatal attendance item for the same patient, on the same day by the same practitioner.

Item 16400 can only be claimed 10 times per pregnancy.

Item 16400 cannot be claimed for an admitted patient of a hospital.

#### **T.4.2. Items for Initial and Subsequent Obstetric Attendances (Items 16401 and 16404)**

From 1 January 2010, new items 16401 and 16404 replace items 104 and 105 for any specialist obstetric attendance relating to pregnancy. This includes any initial and subsequent attendance with a specialist obstetrician for discussion of pregnancy or pregnancy related conditions or complications, or any postnatal care provided to the patient subsequent to the expiration of normal aftercare period. It is still intended that item 16500 will be claimed for routine antenatal attendances.

**T.4.3. Antenatal Care - (Item 16500)**

In addition to routine antenatal attendances covered by Item 16500 the following services, where rendered during the antenatal period, attract fees:-

- (a) Items 16501, 16502, 16504, 16505, 16508, 16509 (but not normally before the 24th week of pregnancy), 16511, 16512, 16514 and 16600 to 16636.
- (b) The initial consultation at which pregnancy is diagnosed.
- (c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
- (d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
- (e) Treatment of an intercurrent condition not directly related to the pregnancy.

Item 16504 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

Item 16514 relates to antenatal cardiotocography in the management of high risk pregnancy. Fees for this service are not attracted when performed during the course of the labour and delivery.

**T.4.4. External Cephalic Version for Breech Presentation - (Item 16501)**

Contraindications for this item are as follows:

- antepartum haemorrhage (APH)
- multiple pregnancy,
- fetal anomaly,
- intrauterine growth retardation (IUGR),
- caesarean section scar,
- uterine anomalies,
- obvious cephalopelvic disproportion,
- isoimmunization,
- premature rupture of the membranes.

**T.4.5. Labour and Delivery - (Items 16515, 16518, 16519 and 16525)**

Fees for management of labour and delivery covered by Items 16515, 16518, 16519 and 16525 includes the following (where indicated):-

- surgical and/or intravenous infusion induction of labour;
- forceps or vacuum extraction;
- evacuation of products of conception by manual removal (not being an independent procedure);
- episiotomy or repair of tears.

Item 16519 covers delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then Item 16520 would be the appropriate item.

In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, fees are payable under Item 16519 provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

Two items in Group T9 provide fees for assistance by a medical practitioner at a Caesarean section. Item 51306 relates to those instances where the Caesarean section is the only procedure performed, while Item 51309 applies when other operative procedures are performed at the same time.

As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, fees would be payable under the appropriate confinement item.

Where, during labour, a medical practitioner hands the patient over to another medical practitioner, fees are payable under Item 16518 for the referring practitioner's services. The second practitioner's services would attract fees under Item 16515 (i.e., management of vaginal delivery) or Item 16520 (Caesarean section). If another medical practitioner is called in for the management of the labour and delivery, fees for the referring practitioner's services should be assessed under Item 16500 for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

At a high risk delivery fees will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk deliveries include cases of difficult vaginal delivery, Caesarean section or the delivery of babies with Rh problems and babies of toxæmic mothers.

#### **T.4.6. Caesarean Section - (Item 16520)**

Fees under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the delivery by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract fees under Item 16519.

#### **T.4.7. Complicated Confinement - (Item 16522)**

Conditions that pose a significant risk of maternal death referred to in Item 16522 include:

- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in Pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or

- pre-existing renal or hepatic failure.

#### **T.4.8. Labour and Delivery Where Care is Transferred by a Participating Midwife - (Items 16527 to 16528)**

Where the inter-partum care of a women is transferred to a medical practitioner by a participating midwife for management of birth, item 16527 or 16528 would apply depending on the service provided.

Where care is transferred by a participating midwife prior to the commencement of labour, items 16519 or 16522 would apply.

#### **T.4.9. Items for Planning and Management of a Pregnancy (Item 16590)**

Item 16590 has been amended to clarify that it is intended to provide for the planning and management of pregnancy that has progressed beyond 20 weeks, where the medical practitioner is intending to undertake the delivery for a privately admitted patient. From 1 January 2010 a new item, 16591, has been introduced to reflect the different responsibilities of GPs and obstetricians who plan to manage the pregnancy, labour and birth, and those who are part of a shared care arrangement. Medical practitioners who do not plan to undertake the delivery of a privately admitted patient should claim item 16591.

#### **T.4.10. Post-Partum Care - (Items 16564 to 16573)**

The Schedule fees for Items 16519 and 16520 cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

- (i) where the medical services rendered are outside those covered by a consultation, e.g, blood transfusion;
- (ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);
- (iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract fees on an attendance basis. The transfer of a patient within a group practice would not qualify for payments under this arrangement except in the case of Items 16515 and 16518. These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;
- (iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;
- (v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

#### **T4.7.2 Normal postnatal care by a medical practitioner would include:-**

- (i) uncomplicated care and check of

- lochia
  - fundus
  - perineum and vulva/episiotomy site
  - temperature
  - bladder/urination
  - bowels
- (ii) advice and support for establishment of breast feeding
  - (iii) psychological assessment and support
  - (iv) Rhesus status
  - (v) Rubella status and immunisation
  - (vi) contraception advice/management

Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract fees.

Items 16564 to 16573 relate to postnatal complications and should not be itemised in respect of a normal delivery. To qualify for fees under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

#### **T.4.11. Interventional Techniques - (Items 16600 to 16636)**

For Items 16600 to 16636, 35518 and 35674 there is no component in the Schedule fee for the associated ultrasound. Fees are attracted for the ultrasound under the appropriate items in Group I1 of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, fees would be payable under the appropriate ultrasound item.

Item 51312 provides a fee for assistance by a medical practitioner at interventional techniques covered by Items 16606, 16609, 16612, 16615, 16627 and 16633.

#### **T.6.1. Pre-anaesthesia Consultations by an Anaesthetist - (Items 17610 to 17625)**

Pre-anaesthesia consultations are covered by items in the range 17610 - 17625.

Pre-anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. A pre-anaesthesia consultation will attract fees under the appropriate items based on **BOTH** the duration of the consultation **AND** the complexity of the consultation in accordance with the requirements outlined in the content-based item descriptions.

Whether or not the proposed procedure proceeds, the pre-anaesthetic attendance will attract fees under the appropriate consultation item in the range 17610 – 17625, as determined by the duration and content of the consultation.

The following provides further guidance on utilisation of the appropriate items in common clinical situations:

- (i) Item 17610 (15 mins or less) – a pre-anaesthesia consultation of a straightforward nature occurring prior to investigative procedures and other routine surgery. This item covers routine pre-anaesthesia consultation services including the taking of a brief history, a limited examination of the patient including the cardio-respiratory system and brief discussion of an anaesthesia plan with the patient.
- (ii) Item 17615 (16-30 mins) - a pre-anaesthesia consultation of between 16 to 30 minutes duration AND of significantly greater complexity than that required under item 17610. To qualify for payments patients will be undergoing advanced surgery or will have complex medical problems. The consultation will involve a more extensive examination of the patient, for example: the cardio-respiratory system, the upper airway, anatomy relevant to regional anaesthesia and invasive monitoring. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.
- (iii) Item 17620 (31-45 mins) – a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and of between 31 to 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations and the formulation of an anaesthesia plan of management of which there should be a written record in the patient notes.
- (iv) Item 17625 (more than 45 mins) - a pre-anaesthesia consultation of high complexity involving all of the requirements of item 17615 and item 17620 and of more than 45 minutes duration. The pre-anaesthesia consultation will also involve evaluation of relevant patient investigations as well as discussion of the patient's medical condition and/or anaesthesia plan of management with other relevant healthcare professionals. An anaesthesia plan of management should be formulated, of which there should be a written record included in the patient notes.

Some examples of advanced surgery that may require a longer consultation under items 17615-17625 would include:

- Bowel resection
- Caesarean section
- Neonatal surgery
- Major laparotomies
- Radical cancer resection
- Major reconstructive surgery eg free flap transfers, breast reconstruction
- major joint arthroplasty
- joint reconstruction
- Thoracotomy
- Craniotomy
- Spinal surgery eg spinal fusion, discectomy
- Major vascular surgery eg aortic aneurysm repair, arterial bypass surgery, carotid artery endarterectomy

Some examples of complex medical problems in relation to items 17615-17625 would include:

- Major cardiac problems – e.g cardiomyopathy, unstable ischaemic heart disease, heart failure
- Major respiratory disease – e.g COPD, respiratory failure, acute lung conditions eg. infection and asthma,
- Major neurological conditions – CVA, intra/extra cerebral haemorrhage, cerebral palsy and/or major intellectual disability, degenerative conditions of the CNS
- Major metabolic conditions – e.g unstable diabetes, uncontrolled hyperthyroidism, renal failure, liver failure, immune deficiency
- Anaesthetic problems – eg past history of awareness, known or anticipated difficulty with securing the airway, malignant hyperpyrexia, drug allergy,
- Other conditions –
  - patients with history of stroke/TIA's presenting for vascular surgery
  - patients on anti-platelet agents presenting for major surgery requiring management of anticoagulant status
  - patients with poor respiratory/cardiac function presenting for major surgery requiring management of perioperative medications, analgaesia and monitoring

**NOTE I:**

It is important to note that:

- patients undergoing the types of advanced surgery listed above but who are otherwise of reasonable health and who, therefore, do not require a longer pre-anaesthesia consultation as provided for under items 17615-17625, would qualify for fees under item 17610; and
- not all patients with complex medical problems will qualify for a longer consultation under items 17615-17625. For example, patients who have reasonably stable diabetes may only require a short consultation, covered under item 17610. Similarly, patients with reasonably well controlled emphysema (COPD) undergoing minor surgery may only require a short pre-anaesthesia consultation (item 17610), whereas the same patient scheduled for an upper abdominal laparotomy and with recent onset angina with the possible need for ICU postoperatively may require a longer consultation.

**NOTE II:**

- Consultation services covered by pain specialists items in the range 2801-3000 cannot be claimed in conjunction with items 17610-17625
- The consultation time under items 17610 – 17625 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- The requirement of a written patient management plan in items 17615-17625 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction GP Management Plans, Team Care Arrangements, items in Group A15 of this schedule.

### **T.6.2. Referred Anaesthesia Consultations - (Items 17640 to 17655)**

Referred anaesthesia consultations (other than pre-anaesthesia attendances) where the patient is referred will be covered by new items in the range 17640 - 17655. These new items replace the use of specialist referred items 104 and 105. Items 104 and 105 will no longer apply to referred anaesthesia consultations provided by specialist anaesthetists.

Referred anaesthesia consultations comprise 4 time-based items utilising 15 minute increments up to and exceeding 45 minutes, in conjunction with content-based descriptors. Services covered by these specialist referred items include consultations in association with the following:

(i) Acute pain management

- postoperative, utilising specialised techniques eg Patient Controlled Analgesia System (PCAS) as an independent service eg pain control following fractured ribs requiring nerve blocks
- obstetric pain management

(ii) Perioperative management of patients

- postoperative management of cardiac, respiratory and fluid balance problems following major surgery
- vascular access procedures (other than intra-operative peripheral vascular access procedures)

Items 17645 – 17655 will involve the examination of multiple systems and the formulation of a written management plan. Items 17650 and 17655 would also entail the ordering and/or evaluation of relevant patient investigations.

**NOTE :**

- It should be noted that the consultation time under items 17640 – 17655 only applies to the period of active attendance on the patient and does not include time spent in discussion with other health care practitioners.
- Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with items 17640 – 17655.
- The requirement of a written patient management plan in items 17645-17655 or the discussion of the management plan with other health care professions, where this occurs, does not relate to and cannot be claimed in conjunction with GP Management Plans or Team Care Arrangement items.

It would be expected that in the vast majority of cases, the insertion of a peripheral venous cannula (other than in association with anaesthesia) where the patient is referred, would attract fees under item 17640. However, in exceptional clinical circumstances, where the procedure is considerably more difficult and exceeds 15 minutes, such as for patients with chronic disease undergoing long term intravenous therapy, paediatric patients or patients having chemotherapy, item 17645 would apply.

### **T.6.3. Anaesthetist Consultations - Other - (Items 17680, 17690)**

A consultation occurring immediately before the institution of major regional blockade for a patient in labour is covered by item 17680.

Item 17690 can only be claimed where all of the conditions set out in (a) to (d) of item 17690 have been met.

Item 17690 can only be claimed in conjunction with a service covered by items 17615, 17620, or 17625.

Item 17690 cannot be claimed where the pre-anaesthesia consultation covered by items 17615, 17620 or 17625 is provided on the same day as admission to hospital for the subsequent episode of care involving anaesthesia services.

**NOTE:** Consultation services covered by pain medicine specialist items in the range 2801-3000 cannot be claimed in conjunction with anaesthesia consultation items 17610 – 17690.

#### **T.7.1. Regional or Field Nerve Blocks - General**

A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, fees will be paid only under the relevant anaesthesia item as set out in Group T10.

Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts fees under the Group T10 anaesthesia item and not the block item in Group T7.

Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract fees under the appropriate Group T7 item.

When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

#### **T.7.2. Maintenance of Regional or Field Nerve Block - (Items 18222 and 18225)**

Fees are attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude fees for an obstetrician performing an epidural block during labour.

When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a fee is not attracted.

#### **T.7.3. Intrathecal or Epidural Injection - (Item 18232)**

This items covers caudal infusion/injection.

#### **T.7.4. Intrathecal or Epidural Infusion - (Items 18226 and 18227)**

Items 18226 and 18227 apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

Fees are only payable under item 18227 where more than 50% of the service is provided in the after hours period, fees would be payable under item 18219.

#### **T.7.5. Regional or Field Nerve Blocks - (Items 18234 to 18298)**

Items in the range 18234 - 18298 are intended to cover the injection of anaesthetic into the nerve or nerve sheath and not for the treatment of carpal tunnel or similar compression syndromes.

Paravertebral nerve block items 18274 and 18276 cover the provision of regional anaesthesia for surgical and related procedures for the management acute pain or of chronic pain related to radiculopathy. Infiltration of the soft tissue of the paravertebral area for the treatment of other pain symptoms does not attract fees under these items. Additionally, items 18274 and 18276 do not cover facet joint blocks/injections. This procedure is covered under item 39013.

Item 18292 may not be claimed for the injection of botulinum toxin, but may be claimed where a neurolytic agent (such as phenol) is used to treat the obturator nerve in patients receiving botulinum toxin injections under items 18354, 18356, or 18358 for a dynamic foot deformity.

#### **T.8.1. Surgical Operations**

Many items in Group T8 of the Schedule are qualified by one of the following phrases:

- "as an independent procedure";
- "not being a service associated with a service to which another item in this Group applies"; or
- "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

##### **As an Independent Procedure**

The inclusion of this phrase in the description of an item precludes payment when:-

- (i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item 36552) in the course of an open operation on the kidney for another purpose;
- (ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larynx or trachea;
- (iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

##### **Not Being a Service Associated with a Service to which another Item in this Group Applies**

"Not being a service associated with a service to which another item in this Group applies" means that a fee is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item 30106.

"Not being a service associated with a service to which Item ..... applies" means that when this item is performed on the same occasion as the reference item no fee is payable. eg item 39330.

### **Not Being a Service to which another Item in this Group Applies**

"Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g. Item 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Fees may be attracted for an item with this qualification as well as fees for another service during the course of the same operation.

### **T.8.3. Multiple Operation Rule**

The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.2.3) are calculated by the following rule:-

- 100% for the item with the greatest Schedule fee
- plus 50% for the item with the next greatest Schedule fee
- plus 25% for each other item.

#### **Note:**

- (a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.
- (b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
- (c) The Schedule fee for payment purposes is the aggregate of the fees calculated in accordance with the above formula.
- (d) For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined above would apply in respect of the services performed by each medical practitioner.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.2, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate fee may be paid.

#### **T.8.4. Procedure Performed with Local Infiltration or Digital Block**

It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional fee is therefore not payable.

#### **T.8.5. Aftercare (Post-operative Treatment)**

##### **Definition**

Services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient. For the purposes of this book, post-operative treatment is generally referred to as "aftercare".

Aftercare is deemed to include all post-operative treatment rendered by medical practitioners, and includes all attendances until recovery from the operation, the final check or examination, regardless of whether the attendances are at the hospital, private rooms, or the patient's home. Aftercare need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

The medical practitioner determines each individual aftercare period depending on the needs of the patient as the amount and duration of aftercare following an operation may vary between patients for the same operation, as well as between different operations.

##### **Private Patients**

WorkCover will not normally pay for any consultations during an aftercare period as the Schedule fee for most operations, procedures, fractures and dislocations listed in WorkCover's Medical Fee Schedule includes a component of aftercare.

There are some instances where the aftercare component has been excluded from the item and this is clearly indicated in the item description.

There are also some minor operations that are merely stages in the treatment of a particular condition. As such, attendances subsequent to these services should not be regarded as aftercare but rather as a continuation of the treatment of the original condition and attract fees. Likewise, there are a number of services which may be performed during the aftercare period for pain relief which would also attract fees.

This includes all items in Groups T6 and T7, and items 39013, 39100, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

Where there may be doubt as to whether an item actually does include the aftercare, the item description includes the words "including aftercare".

If a service is provided during the aftercare phase for a condition not related to the operation, then this can be claimed, provided the account identifies the service as 'Not normal aftercare', with a brief explanation of the reason for the additional services.

If a patient was admitted as a private patient in a public hospital, then unless the item does not include aftercare, no fee is payable for aftercare. If however, a surgeon delegates aftercare to a patient's medical practitioner, then a fee may be apportioned on the basis of 75% for the operation and 25% for the aftercare. Where the fee is apportioned between two or more medical practitioners, no more than 100% of the fee for the procedure will be paid.

If a WorkCover injury and a non-WorkCover condition are assessed at a single consultation, billing can occur for both services provided. The WorkCover component is billed appropriate to the compensable service provided. The non-WorkCover component may be billed as appropriate to that scheme. Where a consultation relates entirely to a non-WorkCover billable service (either before or after that service has taken place), then that consultation is not billable under WorkCover. Any aftercare associated with a non-WorkCover billable service is also not billable under WorkCover.

**Fractures**

Where the aftercare for fractures is delegated to a doctor at a place other than where the initial reduction was carried out, then fees may be apportioned on a 50:50 basis rather than on the 75:25 basis for surgical operations.

Where the reduction of a fracture is carried out by hospital staff in the out-patient or emergency department of a public hospital, and the patient is then referred to a private practitioner for aftercare, fees are payable for the aftercare on an attendance basis.

The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks

Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

**Note:** This list is a guide only and each case should be judged on individual merits.

#### **T.8.6. Abandoned surgery - (Item 30001)**

Item 30001 applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (eg equipment failure). Claims for fees under this item should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

Where an abandoned procedure eligible for a fee under item 30001 attracts an assistant under the provisions of the items listed in Group T9 (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group T9.

Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from group T9. Such claims should include an account endorsement "assistance at abandoned surgery"

or similar and should be accompanied by full clinical details of the circumstances of the operation, including details of the surgery proposed and the reasons for the operation being discontinued.

#### **T.8.7. Repair of Wound - (Items 30023 to 30049)**

The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

Item 30023 covers debridement of traumatic, "deep and extensively contaminated" wound. Fees are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

For the purpose of items 30026 to 30049 the term 'superficial' means affecting skin and subcutaneous tissue including fat and the term 'deeper tissue' means all tissues deep to but not including subcutaneous tissue such as fascia and muscle.

#### **T.8.8. Biopsy for Diagnostic Purposes - (Items 30071 to 30096)**

Needle aspiration biopsy attracts fees on an attendance basis and not under item 30078.

Item 30071 should be used when a biopsy (including shave) of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion. If the shave biopsy results in a definitive excision of the lesion, only 30071 can be claimed.

Items 30071-30096 require that the specimen be sent for pathological examination.

The aftercare period for item 30071 is 2 days rather than the standard aftercare period for skin excision of 10 days.

#### **T.8.9. Lipectomy - (Items 30165 to 30177)**

Multiple lipectomies, e.g., both buttocks and both thighs attract fees under Item 30171 once only, i.e. the multiple operation rule does not apply. Fees are not payable in respect of liposuction, except in the circumstances outlined in Items 45584 and 45585.

Lipectomy items 30165 and 30177 may not be claimed for patients if performed within 12 months after the most recent pregnancy.

Lipectomy items 30165 to 30177 cannot be claimed in association with items 45564, 45565 or 45530. Where the abdomen requires closure with reconstruction of the umbilicus following free tissue transfer (45564, 45565) or breast reconstruction (45530), item 45569 is to be claimed.

#### **T.8.10. Treatment of Keratoses, Warts etc (Items 30185, 30186, 30187, 30189, 30192 and 30195)**

Treatment of seborrheic keratoses by any means, attracts fees on an attendance basis only.

Treatment of fewer than 10 solar keratoses by ablative techniques such as cryotherapy attracts fees on an attendance basis only. Where 10 or more solar keratoses are treated by ablative techniques, fees are payable under item 30192. Where one or more solar keratoses are treated by electrosurgical destruction, simple curettage or shave excision, fees are payable under item 30195.

Warts and molluscum contagiosum where treated by any means attract fees on an attendance basis except where:

- (a) admission for treatment in an operating theatre of an accredited day surgery facility or hospital is required. In this circumstance, fees are paid under item 30189 where a definitive removal of the wart or molluscum contagiosum is to be undertaken.
- (b) fees have been paid under item 30189, and recurrence occurs.
- (c) definitive removal of palmar or plantar warts is undertaken. In these circumstances, where less than 10 palmar or plantar warts are treated, by methods other than ablative techniques alone, fees are paid under item 30186, with fees progressively reducing as for multi operations, and where 10 or more palmar or plantar warts are treated, by methods other than ablative techniques alone, fees are paid as a flat fee under item 30185.
- (d) palmar and plantar warts are treated by laser and require treatment in an operating theatre of an accredited day surgery facility or hospital. In this circumstance, fees are paid under item 30187.

Ablative techniques include cryotherapy and chemical removal.

#### **T.8.11. Cryotherapy and Serial Curettage Excision - (Items 30196 to 30203)**

In items 30196 and 30197, serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

For the purposes of Items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

For the purposes of items 30196 to 30203 (inclusive), an anatomical region is defined as: hand, forearm, upper arm, shoulder, upper trunk or chest (anterior and posterior), lower trunk (anterior or posterior) or abdomen (anterior lower trunk), buttock, genital area/perineum, upper leg, lower leg and foot, neck, face (six sections: left/right lower, left/right mid and left/right upper third) and scalp.

#### **T.8.12. Telangiectases or Starburst Vessels - (Items 30213 and 30214)**

These items are restricted to treatment on the head and/or neck. A session of less than 20 minutes duration attracts fees on an attendance basis.

Item 30213 is restricted to a maximum of 6 sessions in a 12 month period. Where additional treatments are indicated in that period, item 30214 should be used.

Claims for fees under item 30214 should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered.

#### **T.8.13. Sentinel Node Biopsy for Breast Cancer - (Items 30299 to 30303)**

For items 30299 and 30300, both lymphoscintigraphy and lymphotropic dye injection must be used, unless the patient has an allergy to the lymphotropic dye.

For the purposes of these items, the axillary lymph node levels referred to are as follows:

- **Level I** - axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** - axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - axillary lymph nodes extending above the superior border of pectoralis minor.

#### **T.8.14. Dissection of Axillary Lymph Nodes - (Items 30335 and 30336)**

For the purposes of Items 30335 and 30336, the definitions of lymph node levels referred to are set out below.

Anatomically, the dissection extends from below upwards as follows:

- **Level I** - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.
- **Level II** – dissection of axillary lymph nodes up to the superior border of pectoralis minor.
- **Level III** - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

#### **T.8.15. Laparotomy and Other Procedures on the Abdominal Viscera - (Item 30375)**

Procedures on the abdominal viscera may be performed by laparotomy or laparoscopically. Item 30375 covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

#### **T.8.16. Diagnostic Laparoscopy - (Item 30390)**

If a diagnostic laparoscopy procedure is performed at a different time on the same day to another laparoscopic service, the procedures are considered to be un-associated services. The claim for fees should be annotated to indicate that the two services were performed on separate occasions, otherwise the claims will be considered to be a single service.

#### **T.8.17. Major Abdominal Incision - (Item 30396)**

A major abdominal incision is one that gives access through an open wound to all compartments of the abdominal cavity. Item 30396 is intended for open surgical incisions only and not those performed laparoscopically.

#### **T.8.18. Gastrointestinal Endoscopic Procedures - (Items 30473 to 30481, 30484 to 30487, 30490 to 30494, 30680 to 30694, 32084 to 32095, 32103, 32104 and 32106)**

The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

#### ***Cleaning, disinfection and sterilisation procedures***

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

- (i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
- (ii) 'Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting', Department Health and Ageing
- (iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

#### ***Anaesthetic and resuscitation equipment***

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

#### **T.8.19. Revision of Gastric Reduction, Gastroplasty or Bypass - (Item 30514)**

Revision of gastric procedure, for example to correct misplacement of the gastric band or other adverse effects of the initial surgery, involves complete reversal of the initial surgery immediately followed by another reduction, gastroplasty or bypass procedure. For revision item 30514 can be claimed with either item 30511 or 30512, whichever is relevant. For cases where division of adhesions exceeds 45 minutes either item 30378 (laparotomy) or item 30393 (laparoscopy) can also be claimed.

#### **T.8.20. Gastrectomy, Sub-total Radical - (Item 30523)**

The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

#### **T.8.21. Anti reflux Operations - (Items 30527 to 30533, 31464 and 31466)**

These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus fees would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

#### **T.8.22. Endoscopic or Endobronchial Ultrasound +/- Fine Needle Aspiration - (Items 30688 - 30710)**

For the purposes of these items the following definitions apply:

- Biopsy means the removal of solid tissue by core sampling or forceps
- FNA means aspiration of cellular material from solid tissue via a small gauge needle.

The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30710.

Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:

- A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or
- A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg: a pancreatic mass occurring on a background of chronic pancreatitis).

### **T.8.23. Removal of Skin Lesions - (Items 31200 to 31355)**

The excision of warts and seborrheic keratoses attracts fees on an attendance basis with the exceptions outlined in T8.13 of the explanatory notes to this category. Excision of pre-malignant lesions including solar keratoses where clinically indicated are covered by items 31200 to 31240.

The excision of suspicious pigmented lesions for diagnostic purposes attract fees under items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *require* that a specimen has been sent for histological confirmation of malignancy, and any subsequent specimens are sent for histological examination. Confirmation of malignancy *must* be received before itemisation of accounts for payment purposes.

Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, items 31205 to 31240 should be used. Malignant tumours are covered by items 31255 to 31355.

A practitioner providing the first treatment episode for a primary BCC/SCC must use the appropriate item from the following: 31255; 31260; 31265; 31270; 31275; 31280; 31285; or 31290.

Where residual BCC/SCC remains following an initial excision of a primary lesion and the same practitioner is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31256; 31261; 31266; 31271; 31276; 31281; 31286 or 31291.

Where residual BCC/SCC remains following an initial excision of a primary lesion and a practitioner other than the practitioner that performed the previous excision is excising that residual BCC/SCC then the appropriate item must be claimed from the following: 31257; 31262; 31267; 31272; 31277; 31282; 31287 or 31292.

Where a BCC/SCC was removed and complete excision of the lesion was confirmed, but a BCC/SCC has recurred at the primary site, then the items providing for recurrent BCC/SCC would usually apply.

A practitioner excising a recurrent BCC/SCC of the head or neck and who is a specialist in the practice of his or her specialty or a practitioner other than the practitioner who provided previous treatment (where the lesion was removed by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy) must use item 31295.

A practitioner excising a recurrent BCC/SCC from an area other than the head or neck or who otherwise does not meet the criteria as described under item 31295 must use the appropriate item from the following 31258; 31263; 31268; 31273; 31278; 31283; 31288 or 31293.

For the purpose of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

Definitive surgical excision for items 31300 to 31335 is defined as “surgical removal with an adequate margin and, as a result, no further surgery is indicated at that site of excision.

It will be necessary for practitioners to retain copies of histological reports.

Items 31245 and 31250 do not cover shave excision.

**T.8.24. Removal of Skin Lesion From Face - (Items 31235 to 31245, 31265 to 31278, 31310 to 31320)**

For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

**T.8.25. Dissection of Lymph Nodes of Neck - (Items 31423 to 31438)**

For the purposes of these items, the lymph node levels referred to are as follows:-

<b>Level I</b>	Submandibular and submental lymph nodes
<b>Level II</b>	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
<b>Level III</b>	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
<b>Level IV</b>	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
<b>Level V</b>	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

**Comprehensive** dissection involves all 5 neck levels while **selective** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV).

Other combinations of node levels may be removed according to clinical circumstances.

**T.8.26. Excision of Breast Lesions, Abnormalities or Tumours - Malignant or Benign - (Items 31500 to 31515)**

Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: 31500, 31503, 31506, 31509, 31512, 31515 either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

**T.8.27. Subcutaneous Mastectomy - (Items 31521, 31524 and 31527)**

When, after completing a subcutaneous mastectomy a prosthesis is inserted, fees are payable for the latter procedure under Item 45527, the multiple operation formula applying. Claims for fees under item 45585 are not payable in association with 31521 or 31527.

**T.8.28. Fine Needle Aspiration of Breast Lesion - (Item 31533)**

An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

**T.8.29. Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation - (Items 31539 and 31545)**

For the purposes of Items 31539 and 31545, surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons, have experience in the procedure, and Medicare Australia notified of their eligibility to perform this procedure.

The ABBI procedure is contraindicated and should not be performed on the following subset of patients:

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;
- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

**T.8.30. Preoperative Localisation of Breast Lesion Prior to the Use of Advanced Breast Biopsy Instrumentation - (Item 31542)**

For the purposes of item 31542, radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure.

**T.8.31. Per Anal Excision of Rectal Tumour using Stereoscopic Rectoscopy - (Items 32103, 32104 and 32106)**

For the purposes of items 32103, 32104 and 32106, surgeons performing this procedure should be colorectal surgeons and have evidence of the appropriate training which are recognised by the Colorectal Surgical Society of Australasia.

Items 32103, 32104 and 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

#### **T.8.32. Sacral Nerve Stimulation for Faecal Incontinence - (Items 32213 to 32218)**

Based on a review of the available evidence, the Medical Services Advisory Committee found that sacral nerve stimulation for faecal incontinence is contraindicated in all patients under 18 years of age, and in patients 18 years of age or older who:

- are medically unfit for surgery;
- are pregnant or planning pregnancy;
- have irritable bowel syndrome;
- have congenital anorectal malformations;
- have active anal abscesses or fistulas;
- have anorectal organic bowel disease – including cancer;
- have functional effects of previous pelvic irradiation;
- have congenital or acquired malformations of the sacrum; or
- have had rectal or anal surgery within the previous 12 months.

#### **T.8.33. Artificial Bowel Sphincter (items 32220, 32221)**

The safety and effectiveness of artificial bowel sphincters has not been established in children prior to puberty.

An artificial bowel sphincter is contraindicated in:

- patients with inflammatory bowel disease, pelvic sepsis, pregnancy, progressive degenerative diseases and a scarred or fragile perineum
- patients who have had an adverse reaction to radiopaque solution
- patients who engage in receptive anal intercourse.

#### **T.8.34. Varicose veins - (Items 32500 to 32517)**

Item 32500 is restricted to a maximum of 6 treatments in a 12 month period. Where additional treatments are necessary in that period, Item 32501 applies.

In items 32500 and 32501, it is sclerosant which is being injected.

Before item 32501 can be used, it is necessary to demonstrate that truncal reflux in the long or short saphenous veins does not exist on duplex examination. Claims for payment should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where

digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered.

In relation to endovenous laser therapy (ELT) and/or radiofrequency diathermy/ablation, the following rules apply:

- ELT and/or radiofrequency diathermy/ablation are not payable if they are billed under any varicose vein items (32500 to 32517) or vascular item 35321.
- If ELT and/or radiofrequency diathermy/ablation are provided on the same occasion as these MBS items, the ELT and radiofrequency diathermy/ablation services must be itemised separately on the invoice, showing the full fees for each service separately to the fees billed against those items.

#### **T.8.35. Uterine Artery Embolisation - (Item 35410)**

The requirement is for specialist referral by a gynaecologist for uterine artery embolisation.

#### **T.8.36. Endovascular Coiling of Intracranial Aneurysms - (Item 35412)**

This service includes balloon angioplasty and insertion of stents (assisted coiling) associated with intracranial aneurysm coiling. The use of liquid embolics alone is not covered by this item. Digital Subtraction Angiography (DSA) done to diagnose the aneurysm (items 60009 and either 60072, 60075 or 60078) is claimable, however this must be clearly noted on the claim and in the clinical notes as separate from the intra-operative DSA done with the coiling procedure.

#### **T.8.37. Arterial and Venous Patches - (Items 33545 to 33551 and 34815)**

Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.

If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract fees under Item 33545 or 33548 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 33551 would also apply.

#### **T.8.38. Embolectomy or Thrombectomy - (Item 33806)**

A fee is payable once only per extremity, regardless of the number of incisions required to access the artery or bypass graft.

#### **T.8.39. Carotid Percutaneous Transluminal Angioplasty with Stenting - (Item 35307)**

The indications for CEA are: >50% stenosis of carotid artery associated with stroke or transient ischaemic attack; or, >80% asymptomatic carotid stenosis. Medical comorbidities which would be considered to make patients at high risk of anaesthetic perioperative complications at open CEA are: significant coronary artery disease; severe heart failure; severe pulmonary disease; or, age greater than 80 years. Surgical conditions which would make patients unfit for open surgery are: recurrent stenosis post CEA; high cervical internal

carotid lesion (above C2); low common carotid lesion below the clavicle; contralateral carotid occlusion; contralateral laryngeal nerve palsy; tracheostomy; or, prior radiation therapy of the neck or neck dissection.

**T.8.40. Peripheral Arterial or Venous Catheterisation - (Item 35317)**

Item 35317 is restricted to the use of those chemotherapeutic agents other than antibiotic or antiviral agents.

**T.8.41. Peripheral Arterial or Venous Embolisation - (Item 35321)**

Item 35321 does not apply to the service described in that item if the service is provided at the same time as, or in connection with, endovenous laser treatment for varicose veins.

**T.8.42. Vertebroplasty - (Items 35400 and 35402)**

The items do not cover the cost of the cement injected during the procedure.

**T.8.45. Percutaneous Transluminal Coronary Angioplasty - (Items 38309, 38312, 38315 and 38318)**

A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

Each of the items 38309, 38312, 38315 and 38318 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

**T.8.46. Colposcopic Examination - (Item 35614)**

It should be noted that colposcopic examination (screening) of women during the course of a consultation does not attract payment under Item 35614 except in the following circumstances:- (i) where the patient has had an abnormal cervical smear; (ii) where there is a history of ingestion of oestrogen by the patient's mother during her pregnancy; or (iii) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

**T.8.47. Hysteroscopy - (Item 35626)**

Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

**T.8.48. Curettage of Uterus under GA or Major Nerve Block - (Items 35639 and 35640)**

Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract fees under these items but would be paid under Item 35620 where malignancy is suspected, or otherwise on an attendance basis.

**T.8.49. Neoplastic Changes of the Cervix - (Items 35644-35648)**

The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

**T.8.50. Sterilisation of Minors - Legal Requirements - (Items 35657, 35687, 35688, 35691, 37622 and 37623)**

- (i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.
- (ii) Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.
- (iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures. Fees are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the *Health Insurance Act 1973*.

#### **T.8.51. Debulking of Uterus - (Item 35658)**

Fees are payable under Item 35658, using the multiple operation rule, in addition to vaginal hysterectomy.

#### **T.8.52. Nephrectomy - (Items 36526 and 36527)**

Items 36526 and 36527 are only claimable where the practitioner has a high index of suspicion of malignancy which cannot be confirmed by biopsy prior to surgery being performed, due to the biopsy being either clinically inappropriate, or the specimen provided showing an inconclusive diagnosis.

#### **T.8.53. Sacral Nerve Stimulation - (Items 36658, 36660, and 36662)**

Items 36658, 36660, and 36662 only apply in the following circumstances:

- (a) the patient has received a sacral nerve stimulation implant for the management of refractory urinary incontinence or urge retention;
- (b) the patient requires replacement or removal of the pulse generator and/or leads for the neurostimulator device; and
- (c) the service referred to in paragraph (a) was rendered to the patient prior to 30 April 1998 and a fee was paid for that service under item 30000, 39134, 39139 or 39140.

#### **T.8.54. Sacral Nerve Stimulation (items 36663-36668)**

A two-stage process of testing and treatment is required to ensure suitability for Sacral Nerve Stimulation for detrusor overactivity or non obstructive urinary retention where urethral obstruction has been urodynamically excluded. The testing phase involves acute and sub-chronic testing. The first stage includes peripheral nerve evaluation and patients who achieve greater than 50% improvement in urinary incontinence or retention episodes during testing will be eligible to receive permanent SNS treatment.

#### **T.8.55. Ureteroscopy - (Item 36803)**

Item 36803 refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items 36806 or 36809) or pyeloscopy numbers (Items 36652, 36654 or 36656) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopic procedure in another ureter or collecting system. If Item number 36803 is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy

performed in another ureter eg 36654 (Right side) and 36803 (Left side). 36803 may also be used in this way if there is a partial or complete duplex collecting system eg 36809 (Lower pole moiety ureter, Left side) and 36803 (Upper pole moiety ureter, Left side).

T8.51.2 Item numbers 36806 and 36809 may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with 36803 eg 36806 (Right side) and 36809 (Left side).

#### **T.8.56. Selective Coronary Angiography - (Items 38215 to 38246)**

Each item in the range 38215-38240 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

Item 38243 may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

Item 38246 may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service.

Consequently, it may not be billed in conjunction with items 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243. In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

Items in the range 38215 - 38246 cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore fees are not payable for IVUS.

#### **T.8.57. Transurethral Needle Ablation (TUNA) of the Prostate - (Items 37201 and 37202)**

Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as:

- (i) Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is **not** considered to be a serious complication of TURP.
- (ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

#### **T.8.58. Brachytherapy of the Prostate - (Item 37220)**

Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

An approved site is one that has been licensed by the relevant Radiation Advisory Body.

#### **T.8.59. High Dose Rate Brachytherapy - (Item 37227)**

Item 37227 covers the service undertaken by an urologist or radiation oncologist as part of the High Dose Rate Brachytherapy procedure, in association with a radiation oncologist. If the service is undertaken by an urologist, a radiation oncologist must be present in person at the time of the service. The removal of the catheters following completion of the Brachytherapy is also covered under this item.

**T.8.60. Radical or Debulking Operation for Ovarian Tumour - (Item 35720)**

This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy fees are payable under both item numbers with the application of the multiple operation formula.

**T.8.61. Transcutaneous Sperm Retrieval - (Item 37605)**

Item 37605 covers transcutaneous sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies.

Item 37605 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply, in accordance with point T8.5 of these guidelines.

Where the procedure is carried out under local infiltration as the means of anaesthesia, an additional fee is not payable for the anaesthesia component as this is considered to be part of the procedure.

**T.8.62. Surgical Sperm Retrieval, by Open Approach - (Item 37606)**

Item 37606 covers open sperm retrieval for the purposes of intracytoplasmic sperm injection (item 13251) for male factor infertility, in association with assisted reproductive technologies. Item 37606 provides for the procedure to be performed unilaterally. Where it is clinically necessary to perform the service bilaterally, the multiple operation rule would apply.

A fee for item 37606 may be claimed in conjunction with a service or services provided under item 37605, where an open approach is clinically necessary following an unsuccessful percutaneous approach. Likewise, such services would be subject to the multiple operation rule.

A fee is not payable for item 37606 in conjunction with item 37604.

**T.8.63. Cardiac Pacemaker Insertion - (Items 38209, 38212, 38350, 38353 and 38356)**

The fees for the insertion of a pacemaker (Items 38350, 38353 and 38356) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function.

Accordingly, additional fees are not payable for such routine testing under Item 38209 or 38212 (Cardiac electrophysiological studies).

**T.8.64. Implantable ECG Loop Recorder - (Item 38285)**

The fee for implantation of the loop recorder (item 38285) covers the initial programming and testing of the device for satisfactory rhythm capture. Fees are payable only once per day.

The term "recurrent" refers to more than one episode of syncope, where events occur at intervals of 1 week or longer. The term "other available cardiac investigations" includes the following:

- a complete history and physical examination that excludes a primary neurological cause of syncope and does not exclude a cardiac cause;
- electrocardiography (ECG) (items 1170-11702);
- echocardiography (items 55113-55115);
- continuous ECG recording or ambulatory ECG monitoring (items 11708-11711);
- up-right tilt table test (item 11724); and
- cardiac electrophysiological study, unless there is reasonable medical reason to waive this requirement (item 38209).

#### **T.8.65. Transluminal Insertion of Stent or Stents - (Item 38306)**

Item 38306 should only be billed once per occlusional site. It is not appropriate to bill item 38306 multiple times for the insertion of more than one stent at the same occlusional site in the same artery. However, it would be appropriate to claim this item multiple times for insertion of stents into the same artery at different occlusional sites or into another artery or occlusional site. It is expected that the practitioner will note the details of the artery or site into which the stents were placed.

#### **T.8.66. Permanent Cardiac Synchronisation Device (Items 38365, 38368 and 38654)**

Items 38365, 38368 and 38654 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had a CRT device and transvenous left ventricular electrode inserted and who prior to its insertion met the criteria and now need the device replaced.

#### **T.8.67. Intravascular Extraction of Permanent Pacing Leads - (Item 38358)**

For the purposes of Item 38358 specialists or consultant physicians claiming this item must have training recognised by the Lead Extraction Advisory Committee of the Cardiac Society of Australia and New Zealand, and Medicare Australia notified of that recognition. The procedure should only be undertaken in a hospital capable of providing cardiac surgery.

#### **T.8.68. Cardiac Resynchronisation Therapy - (Item 38371)**

Item 38371 applies only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an CRT device capable of defibrillation inserted and who prior to its insertion met the criteria and now need the device replaced.

#### **T.8.69. Implantable Cardioverter Defibrillator - (Items 38384 and 38387)**

Items 38384 and 38387 apply only to patients who meet the criteria listed in the item descriptor, and to patients who do not meet the criteria listed in the descriptor but have previously had an ICD device inserted and who prior to its insertion met the criteria and now need the device replaced.

#### **T.8.70. Cardiac and Thoracic Surgical Items - (Items 38470 to 38766)**

Items 38470 to 38766 must be performed using open exposure or minimally invasive surgery which excludes percutaneous and transcatheter techniques unless otherwise stated in the item.

**T.8.71. Coronary Artery Bypass - (Items 38497 to 38504)**

The fees for Items 38497 and 38498 include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items 38500, 38501, 38503 and 38504. Where harvesting of an artery other than the internal mammary artery is undertaken, fees are payable under Item 38496 on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item 38500, 38501, 38503 or 38504 irrespective of the origin of the arterial graft.

Items 38498, 38501 and 38504 require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

If it is necessary to provide cardiopulmonary bypass items 38498, 38501 and 38504 cannot be claimed. The procedure should be claimed under items 38497, 38500 or 38503 as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

**T.8.72. Re-operation via Median Sternotomy - (Item 38640)**

Fees are payable for Item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Fees are not payable for Item 38640 in association with Item 38656, 38643 or 38647.

**T.8.73. Skull Base Surgery - (Items 39640 to 39662)**

The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

Items 39640 to 39662 cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

**T.8.74. Intradiscal Injection of Chymopapain - (Item 40336)**

The fee for this item includes routine post-operative care. Associated radiological services attract fees under the appropriate item in Group I3.

**T.8.75. Removal of Ventilating Tube from Ear - (Item 41500)**

Fees are not payable under Item 41500 for removal of ventilating tube. This service attracts fees on an attendance basis.

**T.8.76. Meatoplasty - (Item 41515)**

When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

**T.8.77. Reconstruction of Auditory Canal - (Item 41524)**

When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

**T.8.78. Removal of Nasal Polyp or Polypi - (Items 41662, 41665 and 41668)**

Where such polyps are removed in association with another intranasal procedure, a fee is paid under Item 41662. However where the associated procedure is of lesser value than Items 41665/41668, fees for removal of polypi would be paid under Items 41665/41668.

**T.8.79. Larynx, Direct Examination - (Item 41846)**

A fee is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

**T.8.80. Microlaryngoscopy - (Item 41858)**

This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

**T.8.81. Imbedded Foreign Body - (Item 42644)**

For the purpose of item 42644, an imbedded foreign body is one that is sub-epithelial or intra-epithelial and is completely removed using a hypodermic needle, foreign body gouge or similar surgical instrument with magnification provided by a slit lamp biomicroscope, loupe or similar device.

Item 42644 also provides for the removal of rust rings from the cornea, which requires the use of a dental burr, foreign body gouge or similar instrument with magnification by a slit lamp biomicroscope.

Where the imbedded foreign body is not completely removed, fees are payable under the relevant attendance item.

**T.8.82. Corneal Incisions - (Item 42672)**

The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42672.

**T.8.83. Capsulectomy or Lensectomy - (Item 42731)**

The following items would be regarded as intraocular operations, and should not be itemised with Item 42731:

42551 42554 42557 42560 42563 42566 42569 42698 42701 42702 42703 42704  
42707 42716 42722 42725 42734 42740 42743 42746 42761 42764 42767 42815  
42857

This list of exclusions was developed following consultation with the Royal Australian and New Zealand College of Ophthalmologists.

**T.8.84. Posterior Juxtasclear Depot Injection - (Item 42741)**

For the purpose of item 42741, the therapeutic substance must be registered with the Therapeutic Goods Administration (or listed on the Pharmaceutical Benefits Schedule, if so listed) as being suitable for injection for the treatment of predominantly (greater than or equal to 50%) classic, subfoveal choroidal

neovascularisation due to age-related macular degeneration, as diagnosed by fluorescein angiography, in a patient with a baseline visual acuity equal to or better than 6/60.

**T.8.85. Cyclodestructive Procedures - (Items 42770 and 42771)**

Item 42770 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period item 42771 should be utilised.

**T.8.86. Laser Trabeculoplasty - (Items 42782 and 42783)**

Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised.

Payment for item 42783 should be accompanied by full clinical details to verify the need for additional services.

**T.8.87. Laser Iridotomy - (Items 42785 and 42786)**

Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised.

Payment should be accompanied by full clinical details to verify the need for additional services.

**T.8.88. Laser Capsulotomy - (Items 42788 and 42789)**

Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised.

Payment for item 42789 should be accompanied by full clinical details to verify the need for additional services.

**T.8.89. Laser Vitreolysis or Corticolysis of Lens Material or Fibrinolysis - (Items 42791 and 42792)**

Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised.

Payment for item 42792 should be accompanied by full clinical details to verify the need for additional services.

**T.8.90. Division of Suture by Laser - (Item 42794)**

Fees under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

**T.8.91. Laser Coagulation of Corneal or Scleral Blood Vessels - (Item 42797)**

Fees under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

Fees are not payable under Item 42797 for procedures undertaken for cosmetic purposes (see paragraph 13.1.2 of these guidelines).

**T.8.92. Ophthalmic Sutures - (Item 42845)**

This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning, or adjustment performed prior to the patient leaving the operating theatre.

**T.8.93. Full face Chemical Peel - (Items 45019 and 45020)**

These items relate to full face chemical peel in the circumstances outlined in the item descriptors. Invoices should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment have been met. Where digital photographs are supplied, the practitioner must sign each photograph to certify that the digital photograph has not been altered.

**T.8.94. Abrasive Therapy/Resurfacing - (Items 45021 to 45026)**

For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

Items 45021 and 45024 cover abrasive therapy only. For the purposes of these items, abrasive therapy requires the removal of the epidermis and into the deeper papillary dermis. Services performed using a laser are not eligible for payment under these items.

Items 45025 and 45026 do not cover the use of fractional (Fraxel®) laser therapy.

**T.8.95. Foreign Implant - (Item 45051)**

For fees to be payable for this item the intention of the implantation must be either to reconstruct facial or body contours which have been damaged by trauma or disease or to correct a deformity which has been pathologically caused.

**T.8.96. Escharotomy - (Item 45054)**

Fees are payable once only under Item 45054 for each limb (or chest) regardless of the number of incisions to each of these areas.

**T.8.97. Local Skin Flap - Definition**

Fees for flaps are only payable when clinically appropriate. Clinically appropriate in this instance means that the flap or graft is required to close the defect because the defect cannot be closed directly, or because the flap is required to adapt scar position optimally with regard to skin creases or landmarks, maintain contour on the face or neck, or prevent distortion of adjacent structures or apertures

A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A fee is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract fees if closed by graft or flap repair but not when closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position

relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, fees will be paid on the basis of Items 45200, 45203 or 45206 once only.

Items where fees for local skin flap repair (if indicated as above) is payable, include:

30023, 30180, 30186, 30269, 31205-31340, 45030, 45033, 45036-45045, 45506, 45512, 45626.

Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

The following items are examples of where local flap repair would usually not be payable:

30026-30052, 30099-30114, 30165-30177, 31200, 45520, 45522, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

#### **T.8.98. Free Grafting to Burns - (Items 45406 to 45418)**

Items 45406 to 45418 cover split skin grafting using autografts, homografts or xenografts.

#### **T.8.99. Revision of Scar - (Items 45506 to 45518)**

For the purposes of items 45506 to 45518, revision of scar refers to modification of existing scars (traumatic, surgical or pathological) that is designed to decrease scar width, adapt scar position with regard to skin creases and landmarks, release scars from adhering to underlying structures, improve scar contour in keeping with undamaged skin or restore the shape of facial aperture.

Items 45506 to 45518 are only claimable when performed by a specialist in the practice of his or her specialty or where undertaken in the operating theatre of a hospital.

Only items 45506 and 45512, for the face and neck, can be claimed in association with items providing for graft or flap services.

For excision of scar services which do not meet the requirements of the revision of scar items as defined, the appropriate item in the range 31200 to 31240 should be claimed.

#### **T.8.100. Reduction Mammoplasty - (Item 45522)**

Fees are not payable under item 45522 for gynaecomastia. The treatment of gynaecomastia is provided for under either item 31527 or 45585.

#### **T.8.101. Augmentation Mammoplasty - (Items 45524, 45527 and 45528)**

A fee is generally not attracted under item 45524 unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast some time after an initial augmentation of one side would not attract fees. When both mastopexy for breast ptosis (items 45556, 45557 and 45558) and augmentation mammoplasty are performed on the same side, fees are only payable for one or the other procedure, not both procedures. Fees are not payable for augmentation mammoplasty services performed using fat transfer to the breast.

Item 45528 applies where bilateral mammoplasty is indicated because of malformation of breast tissue, disease or trauma of the breast, (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527.

**T.8.102. Breast Reconstruction, Myocutaneous Flap - (Item 45530)**

When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Fees would also be payable for nipple reconstruction (Item 45545) when performed.

When claiming item 45530 for a rectus abdominis flap; item 45569 should be claimed for closure of the abdomen and reconstruction of the umbilicus, and item 45570 may be claimed if repair of the musculoaponeurotic layer is required. When claiming item 45530 for a latissimus dorsi flap, no item for the closure of the musculoaponeurotic layer should be claimed as it is expected that repair will be by direct suture. In the small number of cases, when a latissimus dorsi flap is used, and repair by means other than direct suture is required, use of item 45203 would be appropriate.

Items 30165, 30168, 30171, 30174 or 30177 (lipectomy items) should not be claimed in association with item 45530.

**T.8.103. Breast Prosthesis, Removal and Replacement of - (Items 45552 to 45555)**

It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Fees are not payable for services under items 45552-45555 where the procedure is performed solely to increase breast size.

**T.8.104. Breast Ptosis - (Items 45556 to 45559)**

For the purposes of item 45556, a fee is only payable for the correction of breast ptosis when performed unilaterally, to match the position of the contralateral breast. This item is payable only once per patient. An additional fee is not payable if this procedure is also performed on the contralateral breast or if augmentation mammoplasty is performed simultaneously on the same side.

Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove.

**T.8.105. Nipple and/or Areola Reconstruction - (Items 45545 and 45546)**

Item 45545 involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

Item 45546 covers the non-surgical creation of nipple or areola by intradermal colouration.

**T.8.106. Liposuction - (Items 45584, 45585 and 45586)**

Fees for liposuction are generally attracted under item 45584, that is, for the treatment of post-traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would fees be payable for bilateral liposuction.

Where liposuction is indicated for the treatment of pathological lipodystrophy of hips, buttocks, thighs and knees or lower legs (Barraquer-Simon's Syndrome), gynaecomastia, lymphoedema or macrodystrophia lipomatosa item 45585 applies.

**T.8.107. Meloplasty for Correction of Facial Asymmetry - (Items 45587 and 45588)**

Fees are payable under items 45587 and 45588 for face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.

Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooping from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), item 45588 applies.

For the purpose of items 45587 and 45588 severe acne scarring is defined as scarring on the face or cheeks that is obvious from a distance of 2 metres.

#### **T.8.108. Reduction of Eyelids - (Items 45617 and 45620)**

Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract fees.

#### **T.8.109. Rhinoplasty - (Items 45638, 45639)**

Fees are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

Item 45638 applies where surgery is indicated for correction of nasal obstruction, post-traumatic deformity (but not as a result of previous elective cosmetic surgery), or both.

Item 45639 applies where surgery is indicated for the correction of significant developmental deformity. Developmental deformity includes cleft nose, bifid tip and twisted nose.

#### **T.8.110. Contour Restoration - (Item 45647)**

For the purpose of item 45647, a region in relation to the face is defined as either being upper left or right, mid left or right or lower left or right. Accounts should be annotated with region/s to which the service applies.

#### **T.8.111. Vermilionectomy - (Item 45669)**

Item 45669 covers treatment of the entire lip.

#### **T.8.112. Osteotomy of Jaw - (Items 45720 to 45752)**

The fee for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract an additional fee under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

For the purposes of these items, a reference to maxilla includes the zygoma.

Item 75621 for the provision of fitting of surgical templates may be claimed in association with the appropriate orthognathic surgical items in the range of 45720 to 45754 for prescribed dental patients registered under the Cleft Lip and Cleft Palate Scheme.

#### **T.8.113. Genioplasty - (Item 45761)**

Genioplasty attracts fees once only although a section is made on both sides of the symphysis of the mandible.

**T.8.114. Tumour, Cyst, Ulcer or Scar - (Items 45801 to 45813)**

It is recognised that odontogenic keratocysts, although not neoplastic, often require the same surgical management as benign tumours.

**T.8.115. Fracture of Mandible or Maxilla - (Items 45975 to 45996)**

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

**T.8.116. Reduction of Dislocation or Fracture**

Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, fees are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts fees on an attendance basis.

**T.8.117. Removal of Multiple Exostoses (Items 47933 and 47936)**

Items 47933 and 47936 provide for removal of multiple exostoses when undertaken via the same incision.

**T.8.118. Lumbar Discectomy - (Item 48636)**

Fees are not payable for Intradiscal Electrothermal Annuloplasty (IDETA) procedure. A restriction has been placed on the item 48636 (lumbar discectomy). This item cannot be claimed for IDETA.

**T.8.119. Discectomy in Relation to Anterior Interbody Spinal Fusion - (Items 48660 to 48675)**

Fees are not payable for discectomy items claimed in association with anterior interbody fusion items unless discectomy is required to remove expelled fragments of disc or is undertaken at a level different from where the fusion is performed.

**T.8.120. Internal Fixation - (Items 48678 to 48690)**

Fees under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items 48642 to 48675. The multiple rule would apply in each instance.

**T.8.121A Joint or other synovial cavity, aspiration of, or injection into – (Items 50124 and 50125)**

Items 50124 and 50125 should not be claimed in association with arthroscopy items 48945-48960, 49118-49121, 49218-48227, 49360-49366, 49557-49566, 49700, 49703, 50100 and 50102. Item 50124 is restricted to a maximum of 25 treatments in a 12 month period. Where additional treatments are necessary item 50125 applies.

**T.8.122. Wrist Surgery - (Items 49200 to 49227)**

For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

**T.8.123. Paediatric Patients - (Items 50450 to 50658)**

For payment purposes a paediatric patient is considered to be a patient under the age of eighteen years, except in those instances where an item provides further specifications (i.e. fracture items for paediatric patients which state "with open growth plates").

**T.8.124. Treatment of Fractures in Paediatric Patients - (Items 50500 to 50588)**

Items 50552 and 50560 apply to fractures that may arise during delivery and at an age when anaesthesia poses a significant risk and thus reduction is usually performed in the neonatal unit or nursery.

Item 50576 provides for closed reduction in the skeletally immature patient and will require application of a hip spica cast and related aftercare.

Fees are payable for services that specify reduction with or without internal fixation by open or percutaneous means, where reduction is carried out on the growth plate or joint surface or both.

**T.8.125. Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation - (Item 50952)**

A multi-disciplinary team for the purposes of item 50952 would include a hepatobiliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

**T.9.1. Assistance at Operations - (Items 51300 to 51318)**

Items covering operations which are eligible for payment for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Fees are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to a surgeon no additional fees are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

**NOTE:** The fee in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more medical practitioners.

**Assistance at Multiple Operations**

Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee. The multiple-operation formula is then applied to those items at which assistance was rendered and for which fees for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item 51300 or 51303).

**Multiple Operation Rule - Surgeon**

Item A - \$300@100%

Item B - \$250@50%

Item C - \$200@25%

Item D - \$150@25%

**Multiple Operation Rule - Assistant**

Item A (Assist.) - \$300@100%

Item B (No Assist.)

Item C (Assist.) - \$200@50%

Item D (Assist.) - \$150@25%

The derived fee applicable to Item 51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

**Surgeons Operating Independently**

Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, fees for surgical assistance are payable in the same manner as if the surgeons were operating separately.

**T.9.2. Fees Payable under Item 51300**

Fees are payable under item 51300 for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

**T.9.3. Fees Payable Under Item 51303**

Fees are payable under item 51303 for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

**T.9.4. Fees Payable Under Item 51309**

Fees are payable under item 51309 for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a delivery involving Caesarean section.

Where assistance is provided at a Caesarean section delivery and at a procedure or procedures which have not been identified by the word "Assist.", fees are payable under item 51306.

**T.9.5. Assistance at Cataract and Intraocular Lens Surgery - (Item 51318)**

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

**T.10.1. Relative Value Guide For Anaesthetics - (Group T10)****Overview of the RVG**

The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item 22012) and central vein catheterisation (item 22020) when performed in association with the administration of anaesthesia. These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances. These items are listed at subgroup 26.

The RVG is based on an anaesthesia unit system reflecting the complexity of the service and the total time taken for the service. Each unit has been assigned a dollar value.

Under the RVG, the fee for anaesthesia in connection with a procedure is comprised of up to three components:

The basic units allocated to each anaesthetic procedure, reflecting the complexity of the procedure (an item in the range 20100-21997). For example:

20702	<b>INITIATION AND MANAGEMENT OF ANAESTHESIA</b> for percutaneous liver biopsy (4 basic units)
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the time unit allocation reflecting the **total time** of the anaesthesia (an item in the range 23010-24136), for example;

23033	- 41 MINUTES to 45 MINUTES (3 units)
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plus, where appropriate

**modifying** units recognising certain added complexities in anaesthesia (an item/s in the range 25000-25020), for example

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA where the patients age is less than 12 months of age or 70 years or greater (1 unit)
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Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

25200	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients Derived Fee: An amount of (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 – 25020
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As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item 22060), the total time for the perfusion, and modifying units, as appropriate i.e

(a) the basic units allocated to whole body perfusion under item 22060;

22060	WHOLE BODY PERFUSION, CARDIAC BYPASS, using heart-lung machine or equivalent (20 basic units)
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(b) plus, the **time** unit allocation reflecting the **total time** of the perfusion (an item in the range 23010 – 24136), for example;

23033	41 MINUTES TO 45 MINUTES (3 basic units)
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plus, where appropriate

(c) **modifying** units recognising certain added complexities in perfusion (an item/s in the range 25000 – 25020) for example

25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic units)
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### T.10.2. Eligible Services

Generally, a fee is only payable for anaesthesia which is performed in connection with an “eligible” service. An “eligible” service is defined as a clinically relevant professional service which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.

### T.10.3. RVG Unit Values

#### Basic Units

The RVG basic unit allocation represents the complexity of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

#### Time Units

The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- **for anaesthesia**, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- **for assistance at anaesthesia**, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- **for perfusion**, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

For up to and including the first - 2 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 2 hours, each time unit equates to 10 minutes (or part thereof).

For statistical purposes, the first 2 hours of time after the first 15 minutes is represented in the WorkCover Medical Fee Schedule by item numbers in 5 minute increments. For example:

23010	ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME - for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service - 15 MINUTES OR LESS (1 unit)
23021	- 16 MINUTES TO 20 MINUTES (2 units)
23022	- 21 MINUTES to 25 MINUTES (2 units)
23023	- 26 MINUTES to 30 MINUTES (2 units)

23031	- 31 MINUTES to 35 MINUTES (3 units)
23032	- 36 MINUTES to 40 MINUTES (3 units)
23033	- 41 MINUTES to 45 MINUTES (3 units)

For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

### Modifying Units (25000 – 25050)

Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient's age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

- **ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000).** This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are:

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
  - a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
  - a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
  - a patient who has renal failure requiring regular dialysis.
- **ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005).** This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples:

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:-
- severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or

- severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.
- **ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010).** This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.

**NOTE:** It should be noted that the WorkCover Medical Fee Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2. Some examples of ASA 2 would include:

- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.”
- Where the patient is less than 12 months or age or 70 years or greater (item 25015).
- For anaesthesia, assistance at anaesthesia or a perfusion service in association with an \*emergency procedure (item 25020).
- For anaesthesia or assistance at anaesthesia in association with an \*after hours emergency procedure (items 25025 and 25030).
- For a perfusion service in association with \*after hours emergency surgery (item 25050).

\* **NOTE:** It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.

It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

### ***Definition of Emergency***

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as existing where the patient requires immediate treatment without which there would be significant threat to life or body part.

### ***Definition of After Hours***

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Fees

for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies.

**T.10.4. Deriving the Schedule Fee under the RVG**

The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule is derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION	
RVG	Anaesthesia Service	Units
20840	Anaesthesia for resection of perforated bowel	6
23200	Time – 4 hours 40 minutes	24
25000	Modifier - Physical status	1
22012	Central Venous Pressure Monitoring	3

**After Hours Emergency Services**

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS
20840	Anaesthesia for resection of perforated bowel	6
23190	Time – 4 hours 40 minutes	24
25000	Modifier - Physical status	1
22012	Central Venous Pressure Monitoring	3
	TOTAL UNITS	34
25025	Anaesthesia After Hours Emergency Modifier	

**Definition of Radical Surgery for the RVG**

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems. See notes T10.18 and T10.22 which clarify the definitions of the words "extensive" and "radical" used in items 20192 and 20474.

**Multiple Anaesthesia Services**

T10.4.4.1 Where anaesthesia is provided for services covered by multiple items in the RVG, fees are only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS
20790	Anaesthesia for Cholecystectomy	8
20752	Incisional Hernia	6
23111	Time – 2hrs 30mins	11
25015	Physical Status – Over 70	1

### **Prolonged Anaesthesia**

T10.4.5.1 Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

### **T.10.5. Minimum Requirements for Claiming Fees under Items in the RVG (including sedation)**

Fees for RVG services (including sedation) are only payable where both the staffing and the facility in which the service was rendered meets the following minimum guidelines. These guidelines are based on protocols established by the Australian and New Zealand College of Anaesthetists (ANZCA).

#### **Staffing**

- Techniques intended to produce loss of consciousness must not be used unless an anaesthetist is present to care exclusively for the patient;
- Where the patient is a young child, is elderly or has any serious medical condition (such as significant cardio-respiratory disease or danger of airway compromise), an anaesthetist should be present to administer sedation and monitor the patient;
- In all other cases, an appropriately trained medical practitioner, other than the proceduralist, is required to be in exclusive attendance on the patient during the procedure, to administer sedation and to monitor the patient; and
- There must be sufficient equipment (including oxygen, suction and appropriate medication), to enable resuscitation should it become necessary.

#### **Facilities**

The procedure must be performed in a location which is adequate in size and staffed and equipped to deal with a cardiopulmonary emergency. This must include:

- An operating table, trolley or chair which can be readily tilted;
- Adequate uncluttered floor space to perform resuscitation, should this become necessary;
- Adequate suction and room lighting;
- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient;
- A self inflating bag suitable for artificial ventilation together with a range of equipment for advance airway management;
- Appropriate drugs for cardiopulmonary resuscitation;

- A pulse oximeter; and
- Ready access to a defibrillator.

These requirements apply equally to dental anaesthesia or sedation services provided under items in Group T10, Subgroup 20 of the RVG.

#### **T.10.6. Account Requirements**

Before payment will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of these guidelines are required on the anaesthetist's account:

- the anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. In addition, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- the assistant anaesthetist's account must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- the perfusionist's account must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

#### **T.10.7. General Information**

WorkCover provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

Except in special circumstances, fees are not payable for the administration of anaesthesia listed in Subgroups 1-18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

Fees for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate fees may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.9).

It should be noted that additional fees are not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

A fee derived under the RVG for the administration of anaesthesia is the fee payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.9)

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract payment under the appropriate item in Group T7.

It should be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional fee is therefore not payable.

It may happen that the professional service for which the anaesthesia is administered does not itself attract a fee because it is part of the after-care of an operation. This does not, however, affect the fee payable for the anaesthesia service. A fee is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

#### **T.10.8. Additional Services Performed in Connection with Anaesthesia - Subgroup 19**

Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055-22075) have also been retained in the WorkCover Medical Fee Schedule in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

#### **Items 22012 and 22014**

Fees are payable under items 22012 and 22014 only once for each type of pressure, up to a maximum of 4 pressures per patient per calendar day, and irrespective of the number of practitioners involved in monitoring the pressures.

#### **T.10.9. Assistance in the Administration of Anaesthesia**

The RVG provides for a separate fee to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This fee is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

Therapeutic and Diagnostic services covered by Subgroup 19 items (such as blood transfusion, pressure monitoring, insertion of CVC, etc) are payable only once per patient per anaesthetic episode. Where these services are provided by the assistant anaesthetist these services are eligible for payment only where the same service is not also claimed by the primary anaesthetist

Assistance at anaesthesia in connection with emergency treatment (Item 25200)

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death. Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units or inability to wean critically ill patients from pulmonary bypass.

Assistance in the administration of elective anaesthesia (Item 25205)

A separate fee is payable under Item 25205 for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This fee is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

For the purposes of Item 25205, a 'complex paediatric case' involves one or more of the following:-

- (i) the need for invasive monitoring (intravascular or transoesophageal); or
- (ii) organ transplantation; or
- (iii) craniofacial surgery; or
- (iv) major tumour resection; or
- (v) separation of conjoint twins.

#### **T.10.10. Perfusion Services - (Items 22055 to 22075)**

Perfusion services covered by items 22055-22075 have been included in the RVG format.

The 'Time' component for item 22060 is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

Items 22065, 22070 and 22075 may only be used in association with item 22060.

Fees are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group T8 or the medical practitioner who administers the anaesthesia listed in the RVG in Group T10. The service must be performed by a medical practitioner in order to attract payments. The "on behalf of" provisions do not apply.

#### **T.10.12. Discontinued Procedure - (Item 21990)**

Invoices for Item 21990 should be submitted to the case manager for approval and should include full details of the circumstances, including details of the surgery/procedure which had been proposed and the reason for it being discontinued.

#### **T.10.13. Anaesthesia in Connection with a Procedure not Identified as Attracting a WorkCover fee for Anaesthesia - (Item 21997)**

Payment for Item 21997 is not restricted to the service being performed in connection with a surgical service in Group T8. Item 21997 may be performed with any item in the WorkCover Medical Fee Schedule that has not been identified as attracting a fee for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary.

**T.10.14. Anaesthesia in Connection with a Dental Service - (Items 22900 and 22905)**

Items 22900 and 22905 cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the WorkCover Medical Fee Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an 'eligible' service (as defined in point T10.2) does not apply to dental anaesthesia items 22900 and 22905.

**T.10.15. Anaesthesia in Connection with Cleft Lip and Cleft Palate Repair - (Items 20102 and 20172)**

Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items 20102 and 20172.

**T.10.16. Anaesthesia in Connection with an Oral and Maxillofacial Service - (Category 4 of these guidelines)**

Fees for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4) is derived using the RVG. Fees for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

**T.10.17. Intra-operative Blocks for Post Operative Pain - (Items 22031 to 22050)**

Fees are only payable for intra-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items 22031 to 22050.

**T.10.18. Anaesthesia in Connection with Extensive Surgery on Facial Bones - (Item 20192)**

The term 'extensive' in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

**T.10.19. Intrathecal or Epidural Injection for Control of Post-operative Pain - Initial - (Item 22031)**

Fees are payable under item 22031 for the initial intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, for the control of post-operative pain. Fees are not payable for subsequent intra-operative intrathecal and epidural injection (item 22036) in the same anaesthetic episode. Where subsequent infusion is provided post operatively, to maintain analgesia, fees would be payable under items 18222 or 18225.

**T.10.20. Intrathecal or Epidural Injection for Control of Post-operative Pain - Subsequent - (Item 22036)**

Fees are payable under item 22036 for subsequent intrathecal or epidural injection of a therapeutic substance/s, in association with anaesthesia and surgery, performed intra-operatively, for postoperative pain management, where the catheter is already in-situ. Fees are not payable under this item where the initial injection was performed intra-operatively, under item 22031, in the same anaesthetic episode.

**T.10.21. Regional or Field Nerve Blocks for Post-operative Pain - (Items 22040 - 22050)**

Fees are payable under Items 22040 to 22050 in addition to the general anaesthesia for the related procedure.

**T.10.22. Anaesthesia for Radical Procedures on the Chest Wall - (Item 20474)**

Radical procedures on the chest wall referred to in item 20474 would include procedures such as pectus excavatum.

**T.10.23. Anaesthesia for Extensive Spine or Spinal Cord Procedures - (Item 20670)**

This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items 20600, 20620 and 20630.

**T.10.24. Anaesthesia for Femoral Artery Embolectomy - (Item 21274)**

Item 21274 covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item 20880.

**T.10.25. Anaesthesia for Cardiac Catheterisation - (Item 21941)**

Item 21941 does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item 21943.

**T.10.26. Anaesthesia for 2 Dimensional Real Time Transoesophageal Echocardiography - (Item 21936)**

Fees are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

**T.10.27. Anaesthesia for Services on the Upper and Lower Abdomen - (Subgroups 6 and7)**

Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be:

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be:

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;

- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the jejunum, ileum, or colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

**T.10.28. Anaesthesia for Microvascular Free Tissue Flap Surgery - (Items 20230, 20355, 20475, 20704, 20804, 20905, 21155, 21275, 21455, 21535, 21685, 21785 and 21865)**

Fees are only payable where complete free tissue flap surgery is undertaken involving microsurgical arterial and venous anastomoses. Fees do not apply for microsurgical rotation flaps or for re-implementation of digits or either the hand or the foot.

**T.10.29. Anaesthesia Agent Allergy Testing - (Item 21981)**

Fees are only payable under item 21981 where anaesthetic agent allergy testing is suspected following anaphylactic reaction to anaesthetic agents or cardiovascular collapse in association with anaesthesia.

**T.10.30. Anaesthesia for Endoscopic Ureteric Surgery - Including Laser Procedure - (Item 20911)**

Fees are not payable under item 20911 for diagnostic ureteroscopy.

**T.11.1. Botulinum Toxin - (Items 18350 to 18373)**

The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are neither bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Fees are not payable where an agent other than that specified in the item is used.

The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has generally been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication, unless otherwise specified.

## Category 4 - Oral and Maxillofacial Services

**OM.1.1. Fees for Medical Services Performed by Approved Dental Practitioners**

WorkCover fees are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by a approved dental practitioner approved before 1 November 2004.

Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004 for the provision of oral and maxillofacial surgery services and relevant attendances.

Approved dental practitioners may also request certain diagnostic imaging services – refer to Category 5 – Diagnostic Imaging Services for more information.

### **OM.1.2. Changes to the Scheme Effective from 1 November 2004**

From 1 November 2004, access to Category 4 is restricted to those dental practitioners who were approved by the Minister prior to 1 November 2004. No new approvals will be granted after that date.

### **OM.2.1. Definition of Oral and Maxillofacial Surgery**

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

### **OM.2.2. Services That Can Be Provided**

Dental practitioners holding the FRACDS (OMS) or equivalent who were approved by the Minister prior to 1 November 2004 may perform prescribed oral and maxillofacial services listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery relating to Treatment of Cleft Lip and Cleft Palate Conditions”.

It is emphasised that -

- the sole purpose of granting approval to dental practitioners is to enable payment;
- the services set out in Groups 01 to 011 of the WorkCover Medical Fee Schedule, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which fees are payable when the services are performed by an eligible dental practitioner.

### **OM.3.1. Principles of Interpretation**

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount is payable.

### **OM.3.2. Multiple Operation Rule**

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

#### **NOTE:**

1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
3. The Schedule fee for payment purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

### **OM.3.3. After Care (Post-operative Treatment)**

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

### **OM.3.4. Administration of Anaesthetics by Medical Practitioners**

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of fees (and the procedure has been performed by an approved dental practitioner), fees are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

The Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group T10.

Before the payment of fees for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of additional details are required on the anaesthetist's account:

- The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;
- The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

### **OM.4.1. Consultations - (Items 51700 and 51703)**

The consultation item numbers (51700 and 51703) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery.

The referral must be from a registered dental practitioner or a medical practitioner.

#### **OM.4.2. Assistance at Operations - (Items 51800 and 51803)**

Items covering operations which are eligible for fees for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Fees are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional fees benefits are payable. The assistance fee is the same irrespective of the number of practitioners providing assistance.

##### Fees payable under item 51800

Fees are payable under Item 51800 for assistance rendered at the following procedures:

51900, 51904, 52010, 52018, 52039, 52048, 52051, 52062, 52063, 52066, 52078, 52090, 52092, 52095, 52105, 52108, 52111, 52130, 52138, 52141, 52144, 52147, 52182, 52300, 52303, 52312, 52315, 52321, 52324, 52336, 52339, 52424, 52440, 52452, 52480, 52482, 52600, 52603, 52609, 52612, 52615, 52624, 52626, 52627, 52800, 52803, 52806, 52809, 52818, 52824, 52828, 52830, 53006, 53009, 53016, 53215, 53220, 53225, 53226, 53236, 53239, 53242, 53406, 53409, 53412, 53413, 53415, 53416, 53453, 53460.

Where assistance with any of the above procedures is provided by a medical practitioner, fees are payable under item 51300.

##### Fees payable under Item 51803

Fees are payable under Item 51803 for assistance rendered at the following procedures:

51906, 52054, 52094, 52114, 52117, 52120, 52122, 52123, 52126, 52129, 52131, 52148, 52158, 52184, 52186, 52306, 52330, 52333, 52337, 52342, 52345, 52348, 52351, 52354, 52357, 52360, 52363, 52366, 52369, 52372, 52375, 52378, 52379, 52380, 52382, 52430, 52442, 52444, 52446, 52456, 52484, 52618, 52621, 52812, 52815, 52821, 52832, 53015, 53017, 53019, 53209, 53212, 53218, 53221, 53224, 53227, 53230, 53233, 53414, 53418, 53419, 53422, 53423, 53424, 53425, 53427, 53429, 53455.

or at a combination of procedures (including those identified as payable under item 51800 above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, fees are payable under Item 51303.

##### Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which fees for assistance is payable to determine the abated fee level for assistance.

The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items 51800/51300 or 51803/51303).

The derived fee applicable to Item 51803/51303 is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

#### **OM.4.3. Repair of Wound - (Item 51900)**

Item 51900 covers debridement of “deep and extensively contaminated” wound. Fees are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

#### **OM.4.4. Lipectomy, Wedge Excision - Two or More Excisions - (Item 51906)**

Multiple lipectomies attract fees under Item 51906 once only, i.e. the multiple operation rule does not apply. Fees are not payable in respect of liposuction.

#### **OM.4.5. Upper Aerodigestive Tract Endoscopic Procedure - (Item 52035)**

The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

##### ***Cleaning, disinfection and sterilisation procedures***

Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

- (i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
- (ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and
- (iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

##### ***Anaesthetic and resuscitation equipment***

Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons. These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process.

#### **OM.4.6. Tumour, cyst, Ulcer or Scar - (Items 52036 to 52054)**

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

#### **OM.4.7. Aspiration of Haematoma - (Item 52056)**

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage

#### **OM.4.8. Osteotomy of Jaw - (Items 52342 to 52375)**

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site.

Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 52318 or 52319 for the harvesting, plus item 52130 or 52131 for the grafting.

Where the site of grafting under item 52131 requires closure by single stage local flap, item 52300 may be claimed where clinically appropriate. Clinically appropriate in this instance means that the flap is required to close defects because the defect cannot be closed directly.

A local skin flap is an area of skin or subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by pedicle and is moved to the defect by rotation, advancement or transposition, or a combination of these manoeuvres.

Fees are only payable where the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This latter procedure will also attract fees if closed by graft or flap repair but not been closed by direct suture.

By definition, direct wound closure (e.g. by suture) does not constitute skin flap. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back into the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of the wound prior to suturing is considered a normal part of wound closure and is not considered to skin flap repair.

For the purposes of these items, a reference to maxilla includes the zygoma.

#### **OM.4.9. Genioplasty - (Item 52378)**

Genioplasty attracts fees once only although a section is made on both sides of the symphysis of the mandible.

#### **OM.4.10. Fracture of Mandible or Maxilla - (Items 53400 to 53439)**

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones.

Hence a bilateral fracture of the mandible would be assessed as:

- Item 53409 x 1½;
- two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

#### **OM.4.11. Skin Sensitivity Testing - (Item 53600)**

The allergens are local anaesthetics and the contents of anaesthetic capsules, acrylic and other polymers and metals.

**OM.4.12. Destruction of Nerve Branch by Neurolytic Agent - (Item 53706)**

Item 53706 includes the use of botulinum toxin as a neurolytic agent

**Category 5 - Diagnostic Imaging Services****DIB... What Is A Diagnostic Imaging Service**

A diagnostic imaging service is defined in the *Health Insurance Act 1973* (the Act) as meaning “an R-type diagnostic imaging service or an NR-type diagnostic imaging service to which an item in the DIST applies”.

A diagnostic imaging procedure is defined in the Act as ‘a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services’.

The Schedule fee for each diagnostic imaging service described in the DIST covers both the diagnostic imaging procedure and the reading and report on that procedure by the diagnostic imaging service provider. Exceptions to the reporting requirement are as follows:

- (a) where the service is provided in conjunction with a surgical procedure, the findings may be noted on the operation record (items 55054, 55130, 55135, 55848, 55850, 57341, 57345, 59312, 59314, 60506, 60509 and 61109);
- (b) where a service is provided in preparation of a radiological procedure (items 60918 and 60927).

As for all services, diagnostic imaging services have to be clinically relevant before they are eligible for payment. A clinically relevant service is a service that is generally accepted in the profession as being necessary for the appropriate treatment of the patient.

For NR-type services (and R-type services provided without a request under the exemption provisions – see DID – ‘Exemptions from the written request requirements for R-type diagnostic imaging services’), the clinical relevance of the service is determined by the **providing practitioner**. For R-type services rendered at the request of another practitioner, responsibility for determining the clinical relevance of the service lies with the **requesting practitioner**.

**DIC... Who May Provide A Diagnostic Imaging Service**

Unless otherwise stated, a diagnostic imaging service specified in the DIST may be provided by:

- (a) a medical practitioner; or
- (b) a person, other than a medical practitioner, who:
  - (i) is employed by a medical practitioner; or
  - (ii) provides the service under the supervision of a medical practitioner in accordance with accepted medical practice.

For WorkCover purposes, however, the rendering practitioner is the medical practitioner who provides the report.

Fees are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons, who either bill the patient or the practitioner requesting the service.

*Reports provided by practitioners located outside Australia*

Fees are only payable for services rendered by medical practitioners registered in Australia. Where a service consists of a number of components, such as a diagnostic imaging service, all components need to be rendered in Australia in order to qualify for payment. For diagnostic imaging services, this means that all elements of the service, including the preparation of report on the procedure, would need to be rendered in Australia.

As such, fees are not payable for services which have been reported on by medical practitioners located outside Australia.

## **DID... Requests For Diagnostic Imaging Services**

### **Request requirements**

Fees are not payable for diagnostic imaging services that are classified as R-type (requested) services unless prior to commencing the relevant service, the practitioner receives a signed and dated request from a requesting practitioner who determined the service was necessary.

Before requesting a diagnostic imaging service, the requesting practitioner must turn his or her mind to the clinical relevance of the request and determine that the service is necessary for the appropriate professional care of the patient. For example: an ultrasound to determine the sex of a foetus is not a clinically relevant service (unless there is an indication that the sex of the foetus will determine further courses of treatment, eg. a genetic background to a sex-related disease or condition).

There are exemptions to the request requirements in specified circumstances. These circumstances are detailed under DID -'Exemptions from the written request requirements for R-type diagnostic imaging services'

### **Who may request a diagnostic imaging service**

The following practitioners may request a diagnostic imaging service:

- Specialists and consultant physicians can request any diagnostic imaging service.
- Other medical practitioners can request any service except Magnetic Resonance Imaging Services.
- A medical practitioner, on behalf of the treating practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's treating practitioner.
- Dental Practitioners, Physiotherapists, Chiropractors, Osteopaths and Podiatrists registered or licensed under State or Territory laws can request the following diagnostic imaging services:

**All dental practitioners** may request the following items:

57509, 57515, 57521, 57527, 57901, 57902, 57903, 57906, 57909, 57912, 57915, 57918, 57921, 57924, 57927, 57930, 57933, 57939, 57942, 57945, 57960, 57963, 57966, 57969, 58100, 58300, 58503, 58903, 59733, 59739, 59751, 60100, 60500, 60503.

In addition to these items, oral and maxillofacial surgeons, prosthodontists, dental specialists (periodontists, endodontists, pedodontists, orthodontists) and specialists in oral medicine and oral pathology are also able to request the following items:

***Oral and maxillofacial surgeons***

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56030, 56036, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56101, 56107, 56141, 56147, 56219, 56220, 56224, 56227, 56230, 56259, 56301, 56307, 56341, 56347, 56401, 56407, 56409, 56412, 56441, 56447, 56449, 56452, 56501, 56507, 56541, 56547, 56801, 56807, 56841, 56847, 57001, 57007, 57041, 57047, 57341, 57345, 57703, 57709, 57712, 57715, 58103, 58106, 58108, 58109, 58112, 58115, 58306, 58506, 58521, 58524, 58527, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

***Prosthodontists***

55028, 56013, 56016, 56022, 56028, 56053, 56056, 56062, 56068, 58306, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63334.

***Dental specialists (periodontists, endodontists, pedodontists, orthodontists).***

56022, 56062, 58306, 61421, 61454, 61457, 63334.

***Specialists in oral medicine and/or oral pathology***

55028, 55030, 55032, 56001, 56007, 56010, 56013, 56016, 56022, 56028, 56041, 56047, 56050, 56053, 56056, 56062, 56068, 56101, 56107, 56141, 56147, 56301, 56307, 56341, 56347, 56401, 56407, 56441, 56447, 57341, 57345, 58306, 58506, 58909, 59103, 59703, 60000, 60003, 60006, 60009, 60506, 60509, 61109, 61372, 61421, 61425, 61429, 61430, 61433, 61434, 61446, 61449, 61450, 61453, 61454, 61457, 61462, 63007, 63334.

**Physiotherapists, Chiropractors and Osteopaths may request:**

57712, 57715, 58100 to 58106 (inclusive), 58109, 58112, 58120 and 58121.

**Podiatrists may request:**

55836, 55840, 55844, 57521, 57527.

**Form of a request**

Responsibility for the adequacy of requesting details rests with the requesting practitioner. A request for a diagnostic imaging service does not have to be in a particular form. However, the legislation provides that a request must be in writing and contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item/s of service requested. This includes, where relevant, noting on the request the clinical indication(s) for the requested service. The provision of additional relevant clinical

information can often assist the service provider and enhance the overall service provided to the patient. As such, this practice is actively encouraged.

A written request must be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

***Referral to specified provider not required***

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular provider or that, if the request is addressed to a particular provider, the service must be rendered by that provider.

***Request for more than one service and limit on time to render services***

The requesting practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after the rendering of the first service.

***Contravention of request requirements***

A practitioner who, without reasonable excuse makes a request for a diagnostic imaging service that does not include the required information in his or her request or in a request made on his or her behalf may be guilty of an offence under the *Health Insurance Act 1973*.

A practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements may be guilty of an offence under the *Health Insurance Act 1973*.

***Exemptions from the written request requirements for R-type diagnostic imaging services***

There are exemptions from the general written request requirements (R-type) diagnostic imaging services and these are outlined as follows:

***Consultant physician or specialist***

A consultant physician or specialist is a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist or consultant physician, in a particular specialty.

Except for R-type items which in their description state that a referral is required (such as most R-type items in General Ultrasound and items 59300, 59303), a written request is **not** required for the payment of fees when the diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in his or her specialty and after clinical assessment he/she determines that the service was necessary.

However, if in the referral to the consultant physician or specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined – see *"Additional services"*.

***Additional services***

A written request is not required for a diagnostic imaging service if that service was provided after one which has been formally requested and the providing practitioner determines that, on the basis of the results obtained from the requested service, that an additional service was necessary. However, the following services cannot be self-determined as “additional services”:

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required (practitioners should claim the NR item in these circumstances);
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

### ***Substituted services***

A provider may substitute a service for the service originally requested when:

- the provider determines, from the clinical information provided on the request, that the substituted service would be more appropriate for the diagnosis of the patient's condition; and
- the provider has consulted with the requesting practitioner or taken all reasonable steps to do so before providing the substituted service; and
- the substituted service was one that would be accepted as a more appropriate service in the circumstances by the practitioner's speciality group.

However, the following services cannot be substituted:

- R-type items which in their description (such as most R-type items in General Ultrasound and items 59300, 59303) state that a referral is required;
- MRI services; and
- services not otherwise able to be requested by the original requesting practitioner.

### ***Remote areas***

A written request is not required for the payment of an R-type diagnostic imaging service rendered by a medical practitioner in a remote area provided:

- the R-type service is not one for which there is a corresponding NR-type service; and
- the medical practitioner rendering the service has been granted a remote area exemption for that service.

### ***Definition of remote area***

The definition of a remote area is one that is more than 30 kilometres by road from:

- (a) a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and
- (b) a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

**Emergencies**

The written request requirement does not apply if the providing practitioner determines that, because the need for the service arose in an emergency, the service should be performed as quickly as possible.

**Lost requests**

The written request requirement does not apply where:

- the person who received the diagnostic imaging service, or someone acting on that person's behalf, claimed that a written request had been made for such a service but that the request had been lost; and
- the provider of the diagnostic imaging service or that provider's agent or employee obtained confirmation from the requesting practitioner that the request had been made.

The lost request exemption is applicable only to services that the practitioner could originally request.

**Pre-existing diagnostic imaging practices**

The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. The exemption applies to the services covered by the following Items: 57712, 57715, 57901, 57902, 57903, 57912, 57915, 57921, 58100, 58103, 58106, 58108, 58109, 58112, 58115, 58521, 58524, 58527, 58700, 58924 and 59103.

To qualify for this "grandparent" exemption the providing practitioner must:

- (a) be treating his or her own patient;
- (b) have determined that the service was necessary;
- (c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in payment) of the kind which have been designated "R-type" services from 1 May 1991;
- (d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and
- (e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP) on (03) 8699 0414 or Australian College of Rural and Remote Medicine (ACRRM) on (07) 3105 8200.

Fees are only payable for services exempted under these provisions where the service was provided by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

**Retention of requests**

A medical practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for a period of 18 months commencing on the day on which the service was rendered.

**DIE... Registration of Site Undertaking Diagnostic Imaging Procedures**

All sites (including hospitals) and bases for mobile equipment at or from which diagnostic imaging procedures are performed need to be registered with Medicare Australia.

Registered sites and bases for mobile equipment are allocated a Location Specific Practice Number (LSPN). The LSPN is a unique identifier comprising a six digit numeric and is required on all accounts or receipts for diagnostic imaging services. In addition, fees are not payable unless there is equipment of appropriate type listed on the register for the practice.

### **DIG... Maintaining Records of Diagnostic Imaging Services**

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service. Records of R-type diagnostic imaging services must be retained for a period of 18 months commencing on the day on which the service was rendered.

The records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

Where the provider *substitutes* a service for the service originally requested, the provider's records must include:

- words indicating that the providing practitioner has consulted with the requesting practitioner and the date of consultation; or
- if the providing practitioner has not consulted with the requesting practitioner, sufficient information to demonstrate that he or she has taken all reasonable steps to do so.

For services rendered after a *lost request*, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, eg. how and when.

For *emergency services*, the records must indicate the nature of the emergency.

### **DIH... Contravention of State and Territory Laws and Disqualified Practitioners**

Fees are not payable where a diagnostic imaging service is provided by, or on behalf of, a medical practitioner, and the provision of that service by that practitioner or any other person contravenes a State or Territory law which, directly or indirectly, relates to the use of diagnostic imaging procedures or equipment.

#### **Who might be affected?**

- Anyone who can provide or request a WorkCover-funded diagnostic imaging service might be affected.
- Anyone who has a relevant connection to a provider or a requester, including relatives, bodies corporate, trusts, partnerships and employees may also be affected.

#### **What is prohibited?**

- It is unlawful to ask for, accept, offer or provide a benefit, or make a threat, that is reasonably likely to induce a requester to make diagnostic imaging requests, or is related to the business of providing diagnostic imaging services.

- It is a criminal offence to ask for, accept, offer, or provide a benefit, or make a threat, that is intended to induce requests to a particular provider.
- The prohibitions apply to the provision of fees, or the making of threats, that are directed to a requester by a provider, whether directly or through another person.

**A requester of diagnostic imaging services means:**

- a medical practitioner;
- a dental practitioner, a chiropractor, a physiotherapist, a podiatrist or an osteopath in accordance with Medicare Australia standards;
- a person who employs, or engages under a contract for services, one of the people mentioned above; or
- a person who exercises control or direction over one of the people mentioned above (in his or her professional capacity).

**A provider of a diagnostic imaging service means:**

- a person who renders that kind of service;
- a person who carries on a business of rendering that kind of service;
- a person who employs, or engages under a contract for services, one of the people detailed above; or
- a person who exercises control or direction over a person who renders that kind of service or a person who carries on a business of rendering that kind of service.

**What is permitted?**

It is permitted to:

- share the profits of a diagnostic imaging business, provided the dividend is in proportion to the beneficiary's interest in the business;
- accept or pay remuneration, including salary, wages, commission, provided the remuneration is not substantially different from the usual remuneration paid to people engaged in similar employment;
- make or accept payments for property, goods or services, provided the amount paid is not substantially different from the market value of the property, goods or services;
- make or accept payments for shared property, goods or services, provided the amount paid is proportionate to the person's share of the cost of the property, goods or services and shared staff and/or equipment are not used to provide diagnostic imaging services;
- provide or accept property, goods or services, provided the benefit exchanged is not substantially different from the market value of the property, goods or services;

**What are the penalties for those not complying with the provisions?**

If you breach the provisions, you could potentially be subject to a range of penalties, depending on the kind of breach, including:

- civil penalties;
- criminal offences;

referral to the Medical Board of Australia

## **DIJ... Multiple Services Rules**

### ***Background***

There are several rules that may apply when calculating fees payable when multiple diagnostic imaging services are provided to a patient at the same attendance (same day). These rules were developed in association with the diagnostic imaging profession representative organisations and reflect that there are efficiencies to the provider when these services are performed on the same occasion. Unless there are clinical reasons for doing so, they should be provided to the patient at the one attendance and the efficiencies from doing this reflected in the overall fee charged.

### ***General diagnostic imaging - multiples services***

The diagnostic imaging multiple services rules apply to all diagnostic imaging services. There are three rules, and more than one rule may apply in a patient episode. The rules do not apply to diagnostic imaging services rendered in a remote area by a medical practitioner who has a remote area exemption for that area.

**Rule A.** When a medical practitioner renders two or more diagnostic imaging services to a patient on the same day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by \$5.

**Rule B.** When a medical practitioner renders at least one R-type diagnostic imaging service and at least one consultation to a patient on the same day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee as follows:

- if the Schedule fee for the consultation is \$40 or more - by \$35; or
- if the Schedule fee for the consultation is less than \$40 but more than \$15 - by \$15; or
- if the Schedule fee for the consultation is less than \$15 - by the amount of that fee.

The deduction under Rule B is made once only. If there is more than one consultation, the consultation with the highest Schedule fee determines the deduction amount. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the WorkCover Medical Fee Schedule that is, items 1 to 10816 inclusive.

**Rule C.** When a medical practitioner renders an R-type diagnostic imaging service and at least one non-consultation service to the same patient on the same day, the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by \$5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'non-consultation' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51318;
- Category 4, items 51700 to 53460;
- Cleft Lip and Palate services, items 75001 to 75854

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

#### ***Ultrasound - Vascular***

This rule applies to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance by the same practitioner or at different attendances.

Where more than one vascular ultrasound service is provided to the same patient by the same practitioner on the same date of service, the following formula applies to the Schedule fee for each service:

- 100% for the item with the greatest Schedule fee
- plus 60% for the item with the next greatest Schedule fee
- plus 50% for each other item.

When the Schedule fee for some of the items are the same, the reduction is calculated in the following order:

- 100% for the item with the greatest Schedule fee and the lowest item number
- plus 60% for the item with the greatest Schedule fee and the second lowest item number
- plus 50% for each other item

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 55238 and 55280, item 55238 would be considered the highest.

When calculating the fee, it should be noted that despite the reduction, the collective items are treated as one service for the application of Rule A of the General Diagnostic Imaging Multiple Services rules.

#### ***Magnetic Resonance Imaging (MRI) - Musculoskeletal***

If a medical practitioner performs 2 or more scans from subgroup 12 and 13 for the same patient on the same day, the fees specified for items that apply to the service are affected as follows:

- (a) the item with the highest schedule fee retains 100% of the schedule fee; and
- (b) any other fee, except the highest is reduced by 50%.

Note: If 2 or more Schedule fees are equally the highest, the one with the lowest item number is taken to have the higher fee eg. Item 63322 and 63331, item 63322 would be considered the highest.

If the reduced fee is not a multiple of 5 cents, the reduced fee is taken to be the nearest amount that is a multiple of 5 cents.

In addition, the modifying item for contrast may only be claimed once for a group of services subject to this rule.

If a medical practitioner provides:

- (a) 2 or more MRI services from subgroups 12 and 13 for the same patient on the same day; and
- (b) 1 or more other diagnostic imaging services for that patient on that day

the amount of the fees payable for the MRI services is taken, for the purposes of this rule, to be an amount payable for 1 diagnostic imaging service in applying Rule A of the General Diagnostic Imaging Multiple Services rules.

### **DIK... Group I1 - Ultrasound**

#### **Professional supervision for ultrasound services – R-type eligible services**

Ultrasound services (items 55028 to 55854) marked with the symbol (*R*) with the exception of items 55600 and 55603 are not eligible for a fee unless the diagnostic imaging procedure is performed under the professional supervision of a:

- (a) specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or
- (b) practitioner who is not a specialist or consultant physician who meets the requirements of A or B hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient.
  - A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services entitled the payment.
  - B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner in nursing homes or patients' residences and the rendering of those services entitled payment.

If paragraph (a) or (b) cannot be complied with, ultrasound services are eligible for a fee:

- (i) in an emergency; or
- (ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with paragraph (a) or (b) are available.

**Note:** Practitioners do not have to apply for a remote area exemption in these circumstances.

#### **Sonographer accreditation**

Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing

Professional Development program and be Registered on the Register of Accredited Sonographers held by Medicare Australia

### ***Eligibility for registration***

In general, to be eligible for registration, the person must:

- hold an accredited postgraduate qualification in medical ultrasound; or
- be studying ultrasound; or
- have worked as a sonographer under the direction of a medical practitioner in Australia or New Zealand (conditions apply - for assessment of eligibility status, please contact the Australasian Sonographer Accreditation Registry).

### ***Report requirements***

The sonographer's initial and surname is to be written on the report. The name of the sonographer is not required to be included on the copy of the report given to the patient. For the purpose of this rule, the "name" means the sonographer's initial and surname.

### ***Fees payable***

As a rule, benefit is payable **once only** for ultrasonic examination at the **one attendance**, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, *attendance* means that there is a clear separation between one service and the next. For example, where there is a short time between one ultrasound and the next, fees will be payable for one service only.

Where more than one ultrasound service is rendered on the one occasion and the service relates to a non-contiguous body area, and they are "clinically relevant", (ie. the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), fees greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Fees for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

## **Subgroup 1 – General Ultrasound**

### **Post-void residual items 55084 and 55085**

When a post-void residual is the only service clinically indicated and/or rendered, it is inappropriate to report a pelvic, urinary or abdominal ultrasound, instead of or in addition to this service (55084 or 55085). Similarly, if a complete pelvic, urinary or abdominal ultrasound is billed, it is inappropriate to bill separately for a post-void residual determination, since payment of this has already been included in the payment for the complete scans.

The report must contain an entry denoting the post-void residual amount and/or bladder capacity as calculated/estimated from the ultrasound device. In addition, the medical record must contain documentation of the indication for the service and the number of times performed.

### **Subgroup 3 - Vascular ultrasound**

#### **Fees payable**

Fees are only payable for:

- a maximum of two vascular ultrasound studies in a seven-day period. A vascular ultrasound study may include one or more items. Additionally where a patient is referred for a bilateral study of both arms or both legs (eg both arms for item 55238), the account should indicate 'bilateral' or 'left' and 'right' to enable benefit to be paid.
- clinically relevant services, that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered. Any decision to have a patient return on a different day to complete a multi-area diagnostic imaging service should only be made on the basis of clinical necessity.

#### **Multiple Vascular Ultrasound Services**

##### **Separation of services on the one day/contiguous and non-contiguous body areas**

These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

##### **Examination of peripheral vessels**

Vascular ultrasound services can be claimed in conjunction with item 11612.

### **Subgroup 4: Urological ultrasound**

#### **Transrectal ultrasound (Items 55600 and 55603)**

Fees for these items are payable where the service is rendered in the following circumstances:

- a digital rectal examination of the prostate was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the transducer probe or probes used meets specifications of normal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz and which can obtain both axial and sagittal scans in 2 planes at right angles; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Item 55600 covers the situation where the service was rendered by a medical practitioner who **did not** assess the patient, whereas item 55603 covers the situation where the service was rendered by a medical practitioner who **did** assess the patient.

### **Subgroup 5: Obstetric and Gynaecological ultrasound**

#### **NR Services**

Fees are not payable for more than three NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any one pregnancy.

### **Clinical indications**

For items where clinical indications are listed (items 55700, 55704, 55707, 55718, 55759 and 55768), or where a clinical indication is required (items 55712, 55721, 55764 and 55772) for performance of subsequent scans the referral must identify the relevant clinical indication for the service.

It should be noted that a patient must have previously had either a 55706 or 55709 ultrasound in the same pregnancy to be eligible to claim for either a 55712 or 55715 obstetric service. To be eligible to claim for either a 55721 or 55725 obstetric service, a patient must have previously had either a 55718 or 55723 ultrasound in the same pregnancy.

If the service is self-determined (items 55703, 55705, 55708, 55715, 55723, 55725, 55762, 55766, 55770 and 55774), the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

### **Dating of pregnancy**

When dating a pregnancy for the purpose of items 55700 to 55774, a patient is:

- a) "less than 12 weeks of gestation" means up to 11 weeks and 6 days of pregnancy;
- b) "12 to 16 weeks of gestation" means from 12 weeks 0 days of pregnancy up to 16 weeks plus 6 days of pregnancy (inclusive);
- c) "17 to 22 weeks of gestation" means from 17 weeks 0 days of pregnancy up to 22 weeks plus 6 days of pregnancy (inclusive); or
- d) "after 22 weeks of gestation" means from 23 weeks 0 days of pregnancy onwards
- e) "after 24 weeks of gestation" means from 25 weeks 0 days of pregnancy onwards.

### **Nuchal Translucency Testing**

Where a nuchal translucency measurement is performed when the pregnancy is dated by a crown rump length of 45-84mm in conjunction with items 55700 (R ) or 55703 (NR) or 55704 (R) or 55705 (NR), then items 55707 (R ) or 55708 (NR) should be claimed. If nuchal translucency measurement for risk of foetal abnormality is performed in conjunction with any additional condition in items 55700, 55703, 55704 or 55705, only one fee is payable.

It should be noted that the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) provides a credentialling program for providers of nuchal translucency scans. It is anticipated that use of items 55707 and 55708 will be restricted to credentialed medical practitioners and sonographers in the future.

### **Multiple pregnancies**

Obstetric ultrasound items 55759 to 55774 cover scanning of a patient who is experiencing a multiple pregnancy. The items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items

apply only to patients where a multiple pregnancy has been confirmed by ultrasound. The items include identical restrictions and provisions as the second and third trimester items (55706-55725), and include items for referred and non-referred services.

### **Obstetric ultrasound and non-metropolitan providers (Items 55712, 55721, 55764 and 55772)**

Where a practitioner has obstetric privileges at a non-metropolitan hospital and refers for items 55712, 55721 and 55764 and 55772, the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

In relation to items 55712, 55721, 55764 and 55772, non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999).

### **Subgroup 6: Musculoskeletal (MSK) ultrasound**

#### **Personal attendance**

Fees are only payable for a musculoskeletal ultrasound service (items 55800 to 55854) if the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient. Services that are performed because of medical necessity in a remote location are exempt from this requirement. Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

#### **Equipment**

Items 55800 to 55854 only apply to an ultrasound service performed using an ultrasound system which has available on-site a transducer capable of operation at, at least 7.5 megahertz.

#### **Multiple Musculoskeletal Ultrasound Scans - items 55800 to 55846**

Generally fees are payable for more than one musculoskeletal ultrasound scan performed on the same day, however the scans are subject to Rule A of the general diagnostic imaging multiple services rules.

It is not permitted to split a bilateral scan. Where bilateral ultrasound scans are performed (or more than one area is scanned under items 55844 or 55646) the relevant item should be itemised once only. For example if both shoulders are scanned, Item 55808 (or 55810 as the case may be) should be claimed once only. This is because the item descriptor for these items covers one or both sides, or one or more areas. A patient should not be asked to make a second appointment in order to attract a benefit for multiple scans.

#### **Shoulder and knee (Items 55808 and 55810 and 55828 and 55830)**

Fees for shoulder ultrasound items 55808 and 55810 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Fees are not payable when referred for non-specific shoulder pain alone.

Fees for knee ultrasound items 55828 and 55830 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Fees are not payable when referred for non-specific knee pain alone or other knee conditions including:

- meniscal and cruciate ligament tears; and
- assessment of chondral surfaces.

### **DIL... Group I2 - Computed Tomography (CT)**

#### **Capital sensitive items**

A reduced Schedule fee applies to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago. A range of items cover services provided on older equipment. These items are:

56041, 56047, 56050, 56053, 56056, 56062, 56068, 56070, 56076, 56141, 56147, 56259, 56341, 56347, 56441, 56447, 56449, 56452, 56541, 56547, 56659, 56665, 56841, 56847, 57041, 57047, 57247, 57345, 57355.

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply.

Items 56001 to 57356 (which contain the symbol (K) at the end of the item should be used for services which are performed on a date which is less than ten years after the date on which the CT equipment used in performing the service was first installed in Australia. In the case of imported pre-used CT equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

For the purposes of capital sensitive items CT equipment includes the following components:

- (a) a gantry;
- (b) a couch;
- (c) a computer; and
- (d) an operator station.

#### **Professional supervision**

CT services (items 56001 to 57356) are not eligible for a payment unless the service is performed:

- (a) under the professional supervision of a specialist in the specialty of diagnostic radiology who is available:
  - (i) to monitor and influence the conduct and diagnostic quality of the examination; and
  - (ii) if necessary, to personally attend on the patient; or
- (b) if paragraph (a) cannot be complied with
  - (i) in an emergency, or
  - (ii) because of medical necessity in a remote area – refer to DID.4.4 for definition of remote area.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

**Use of a hybrid PET/CT or SPECT/CT machine**

CT scans rendered on hybrid Positron Emission Tomography (PET)/CT or hybrid Single Photon Emission Computed Tomography (SPECT)/CT units are eligible for payment:

- the CT scan is not solely used for the purposes of attenuation correction and anatomical correlation of any associated PET or SPECT scan; and
- the CT scan is rendered under the same conditions as those applying to services rendered on stand-alone CT equipment. For example, the service would need to be properly requested and performed under the professional supervision of a specialist radiologist, including specialist radiologists with dual nuclear medicine qualifications.

**Scan of more than one area**

Items have been provided to cover the common combinations of regions – see Multiple Regions below. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, item 57001 (scan of brain) and item 56619 (scan of extremities), both examinations would attract separate benefit.

**Multiple regions**

Items have been provided to cover the common combinations of regions. The items relating to the individual contiguous regions should not be used when scans of multiple regions are performed.

**More than one attendance of the patient to complete a scan**

Items 56220 to 56240 and 56619 to 56665 apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service. For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, fees are payable for one combination service only upon completion.

**Pre contrast scans**

Pre contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

**Head*****Exclusion of acoustic neuroma***

If an axial scan is performed for the exclusion of acoustic neuroma, fees are payable under item 56001 or 56007.

***Assessment of headache***

If the service described in item 56007 or 56047 is used for the assessment of headache of a patient, the fee mentioned in the item applies only if:

- (a) a scan without intravenous contrast medium has been undertaken on the patient; and
- (b) the service is required because the result of the scan is abnormal.

This rule applies to a patient who:

- (i) is under 50 years; and
- (ii) is (apart from the headache) otherwise well; and
- (iii) has no localising symptoms or signs; and
- (iv) has no history of malignancy or immunosuppression.

### **Spine**

CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. These items are 56220 to 56240 inclusive. They include items for CT scans of two regions of the spine (56233, 56234, 56235 and 56236) and for all three regions of the spine (56237, 56238, 56239 and 56240). Restrictions apply to the following items:

- (a) item 56233 is used where two examinations of the kind referred to in items 56220, 56221 and 56223 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
- (b) item 56234 is used where two examinations of the kind referred to in items 56224, 56225 and 56226 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed.
- (c) item 56235 is used where two examinations of the kind referred to in items 56227, 56228 and 56229 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
- (d) item 56236 is used where two examinations of the kind referred to in items 56230, 56231 and 56232 are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

*Example:* for a CT examination of the spine where the cervical and thoracic regions are to be studied (item 56233), item numbers 56220 and 56221 must be specified.

### **With intrathecal contrast medium (Item 56219)**

The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Fees are not payable for this item when rendered in association with myelograms (Item 59724). Where a myelogram is rendered under item 59724 and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (Item 56220, 56221 or 56223).

### **Upper abdomen and pelvis**

Items 56501, 56507, 56541 and 56547 are not eligible for payment if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). CT Colonography is covered by items 56552 and 56554.

### **Computed Tomography of the Colon (Items 56552 and 56554)**

In items 56552 and 56554 the terms 'high risk' and 'incomplete colonoscopy' are defined as follows:

**High Risk**

Asymptomatic people fit into this category if they have:

- three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected hereditary non-polyposis colorectal cancer or NPCC), or
- two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:
  - multiple bowel cancers in the one person
  - bowel cancer before the age of 50 years
  - at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain
- at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatous polyposis or FAP), or
- somebody in the family in whom the presence of a high-risk mutation in the adenomatous polyposis coli (APC) gene or one of the mismatch repair (MMR) genes has been identified.

Source: NHMRC 2005 Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer - Category 3 - those at potentially high risk.

**Incomplete Colonoscopy**

For audit purposes, an incomplete colonoscopy is defined as one that is not completed for technical or medical reasons and must have been performed in the preceding 3 months.

**Spiral angiography****Items 57350 and 57355 and items 57351 and 57356**

CT spiral angiography items 57351 and 57356 apply under certain circumstances specified in the items including where a service to which items 57350 or 57355 have been performed on the same patient within the previous 12 months, whereas items 57350 and 57355 apply under the circumstances specified in the items and where the service has **not** been performed on the same patient within the previous 12 months.

**Spiral angiography/chest items not to be used to image the coronary arteries**

The descriptors for CT spiral angiography items 57350, 57351, 57355 and 57356 and CT chest items 56301, 56307, 56341, 56347, 56801, 56807, 56841, 56847, 57001, 57007, 57041 and 57047 clarify that they are not to be used to image the coronary arteries.

**DIM... Group I3 - Diagnostic Radiology****Examination and report**

As for all diagnostic imaging services, the fees allocated to each item from 57506 to 60509 inclusive cover the total service, ie. the image, reading and report. Separate fees are not payable for individual components

of the service, eg preliminary reading. Fees are not separately payable for associated plain films involved with these items.

### **Exposure of more than one film**

Where the radiographic examination of a specific area involves the exposure of more than one film, fees are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination. This means that if a x-ray of the foot is requested, regardless of the number of exposures from different angles, the completed service comprises x-ray of the foot by one or more exposures and the report. The exception to this would be the plain x-ray of the spine items (58100 to 58115) where the item number differs dependent upon the regions of the spine that are examined at the same occasion, ie. 58112 applies where two regions are examined.

### **Comparison X-rays**

Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, fees are payable for radiographic examination and reporting of one limb only. Comparison views are considered to be part of the examination requested.

## **Subgroup 4: Radiographic examination of the spine**

### ***Multiple regions***

Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment form completed.

### **Item 58112 - spine, two regions**

Where item 58112 is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (ie from items 58100, 58103, 58106 and 58109).

*Example:* for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers 58100 and 58103 must be specified on any account issued.

### **Item 58115 – spine, three region**

Where item 58115 is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items 58100, 58103, 58106 and 58109).

*Example:* for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers 58100, 58103 and 58106 must be specified on any accounts issued.

### **Item 58115 & 58108 – spine, three and four region**

For three and four region radiographic examinations items 58115 and 58108 do not apply when requested by a physiotherapist, chiropractor or osteopath.

### **Items 58120 and 58121**

Items 58120 and 58121 apply to physiotherapists, chiropractors and osteopaths who request a three or four region x-ray and only allow a benefit for one of the items, per patient, per calendar year.

### ***Hand and wrist combination X-ray***

An examination of the hand and the wrist on the same side should be claimed as item 57512 (NR) or 57515 (R). If items 57506 (NR) or 57509 (R) are claimed for multiple non-adjacent areas on the same side, or areas on different sides, the account should include annotation on this eg L and R hand, hand and humerus.

***Images produced using Dual Energy X-ray Absorptiometry (DEXA) equipment***

X-ray items of the spine 58100 to 58115 and hip 57712 and 57715 cannot be claimed when images are produced using Dual Energy X-ray Absorptiometry (DEXA) equipment.

**Subgroup 8: Radiographic examination of alimentary tract and biliary system**

***Plain abdominal film (Items 58900/58903)***

Fees are not attracted for Items 58900/58903 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

**Subgroup 10: Radiographic examination of the breasts**

***Request requirements (items 59300 and 59303)***

Fees under items 59300 and 59303 are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the requesting medical practitioner is required to include in the request the clinical indication for the procedure. The requesting practitioner must personally sign the request.

The reference to “with or without thermography” has been removed from the item descriptor for items 59300 and 59303 with effect from 1 November 2003. The Radiology Management Committee (RMC) at its meeting of 12 August 2003, agreed that there is no current scientific evidence to support the use of thermography in the early detection of breast cancer and in the reduction of mortality.

***Professional supervision***

Mammography services (items 59300 to 59318) are not eligible for payment unless the diagnostic imaging procedure is performed under the professional supervision of a:

- (a) specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and, if necessary, to personally attend on the patient; or
- (b) if paragraph (a) cannot be complied with:
  - (i) in an emergency; or
  - (ii) because of medical necessity in a remote location.

Note: Practitioners do not have to apply for a remote area exemption in these circumstances.

**Subgroup 12: Radiographic examination with opaque or contrast media**

***Myelogram (Item 59724)***

Fees are not payable where a myelogram is rendered in association with a CT myelogram (Item 56219 - see DIL.9.1). Where it is necessary to render a CT and a myelogram, CT Items 56220, 56221 and 56223 would apply.

### **Subgroup 13: Angiography**

#### ***Angiography services - meaning of (K) and (NK)***

A reduced Schedule fees applies to cardiac angiography services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of items cover services provided on older equipment. These items are 59971, 59972, 59973 and 59974, are identified by the addition of the letters '(NK)' at the end of the item and should be used where services are performed on equipment ten years old or older.

Items 59903, 59912, 59925 and 59970 have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

#### ***Digital subtraction angiography (DSA) (Items 60000-60078)***

Fees are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). Fees are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), fees are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078).

If a DSA examination covers more than one of the specified regions/combinations, then the region/comboination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

### **Subgroup 16: Preparation for radiological procedure**

#### ***Preparation items (Items 60918 and 60927)***

Items 60918 and 60927 apply only to the preparation of a patient for a radiological procedure for a service to which any of items 59903 to 59974 apply. A report is not required for these services.

### **DIN... Group I4 - Nuclear Medicine Imaging**

#### **General**

Fees for a nuclear scanning service are only payable when the service is performed by a specialist or consultant physician, or by a person acting on behalf of the specialist and the final report of the service is

compiled by the specialist or consultant physician who performed the preliminary examination of the patient and the estimation and administration of the dosage.

Additional fees will only be attracted for specialist physician or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note of referral.

### **Credentiailling for nuclear medicine imaging services**

Payment for nuclear medicine imaging services is limited to specialists or consultant physicians who are credentiailled by the Joint Nuclear Medicine Credentiailling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

### **Radiopharmaceuticals**

The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals.

### **Single Photon Emission Computed Tomography (SPECT)**

Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no fee is payable for the SPECT study.

### **Single myocardialperfusion studies (Items 61302 and 61303)**

Items 61302 and 61303 apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

### **Myocardial perfusion (Items 61306 and 61307)**

Items 61306 and 61307 refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

### **Hepatobiliary study (pre-treatment) (Item 61360)**

Item 61360 - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

### **Hepatobiliary study (infusion) (Item 61361)**

Item 61361 applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

### **Whole body studies (Items 61426-61438)**

"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

### **Repeat studies (Item 61462)**

Item 61462 covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item 61462 and the original item and date of service should be indicated for reference purposes.

This item does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee.

### **Thyroid study (Item 61473)**

Item 61473 incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

**Positron Emission Tomography (PET) Items 61523, 61529, 61541, 61544, 61553, 61556, 61559, 61565, 61568, 61577, 61580, 61598, 61604, 61610 and 61613.** WorkCover fees for PET services is limited to credentialled specialists or consultant physicians who meet eligibility requirements under Medicare. PET services must be:

1. provided in a comprehensive facility that can provide a full range of diagnostic imaging services (including PET, CT, X-Ray and diagnostic ultrasound) and cancer treatment services (including chemotherapy, radiation oncology and surgical oncology) at the one site;
2. provided using equipment that meets each of the standards specified by ANZAPNM as detailed in the following:
  - a) The Requirements for PET Accreditation (Instrumentation & Radiation Safety) dated 4 May 2007 and issued by the Australian and New Zealand Society of Nuclear Medicine; and
  - b) NEMA NU 2-2007 Standard published by the National Electrical Manufacturers Association (USA).
3. only provided following referral from a recognised specialist or consultant physician.

## **DIO... Group I5 - Magnetic Resonance Imaging**

### **Itemisation**

MRI items in Group I5, items 63001 to 63497, are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and the number of occasions in a defined period in which fees may be claimed by a patient. Subgroups are divided into individual items, with each item being for a specific clinical indication.

### **Appropriate Eligible services**

Group I5 items apply only to a MRI or MRA service performed:

- (a) on request by a recognised specialist or consultant physician, where the request made in writing identifies the clinical indication for the service;
- (b) under the professional supervision of an appropriate eligible provider.

### **Requests**

A request must be in writing and identify the clinical indications for the service.

MRI services can only be requested by a recognised specialist medical practitioner or consultant physician for the purpose of the *Health Insurance Act 1973*. However, there are exceptions to this provision for a limited number of MRI:

- All dental specialists, prosthodontists, oral and maxillofacial surgeons, oral medicine specialists and oral pathology specialists may request item 63334 – scan of musculoskeletal system for derangement of the temporomandibular joint (s); and
- Oral and maxillofacial surgeons and oral medicine and oral pathology specialists can also request item 63007 – scan of the head for skull base or orbital tumour.

### **Professional supervision**

Group I5 items must be performed as follows:

- (a) under the professional supervision of an appropriate provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; or
- (b) if paragraph (a) is not complied with:
  - (i) in an emergency; or
  - (ii) because of medical necessity, in a remote location (refer to DID).

**Note:** Practitioners do not have to apply for a remote area exemption in these circumstances.

### **Appropriate providers**

In Group I5, an appropriate provider is a specialist in diagnostic radiology who:

- (a) is a participant of the Royal Australian and New Zealand College of Radiologists' (RANZCR) Quality and Accreditation Program.

### **Number of appropriate eligible services**

The frequency of MRI services is to be based on justifiable clinical requirements.

### **MRI Musculoskeletal (MSK) Multiple Services**

#### **Restrictions between MRI/MRA**

When services in subgroups 1, 2, 4, 5 and 14 (MRI of the Head, Head and Cervical Spine or Cardiovascular system) and services from subgroups 3 and 15 (Magnetic Resonance Angiography) are performed on a single occasion, only the MRI fee is claimable.

Example: Service 63064, MRI scan of head for stroke, is performed on the same occasion as service 63401, MRA scan for vascular abnormality. In this circumstance only item 63064 may be claimed.

### **Modifying Items**

Subgroup 22 contains a number of items which modify the value of the MRI/MRA service claimed for the additional cost or complexity of performing a service on a patient who is sedated, under a general anaesthetic or is undergoing a service requiring the use of contrast. These items may only be claimed in conjunction with an eligible MRI/MRA service.

The modifying items are not considered to be services for the diagnostic imaging multiple services rules.

### **Contrast**

- Services eligible for use with contrast are denoted by (Contrast).
- If more than one service is completed in which contrast is used, item 63491 may be claimed for each eligible service, except where restricted by another rule.

### **Anaesthetic and Sedation**

- The anaesthetic modifier is for use by the eligible provider performing the scan, not the Anaesthetist. Fees for Anaesthesia services are payable under Category 3 (Therapeutic Procedures), section T10 (Relative Value Guide). The minimum requirements for anaesthesia (including sedation) are listed in section T10.5 of the explanatory notes in section T10.
- The modifiers for sedation and anaesthetic may not be claimed together, if a patient is both sedated and anaesthetised only the anaesthetic modifier should be claimed.

If more than one scan is provided on a single occasion in which sedation or anaesthetic is used, either item 63494 or 63497 may only be claimed on the first scan.

## **Category 6 - Pathology Services**

### **P.1.1. Pathology Services in Relation to fees - Outline of Arrangements**

#### **Basic Requirements**

#### ***Determination of Necessity of Service***

The treating practitioner must determine that the pathology service is necessary.

#### ***Request for Service***

The service may only be provided:

- (i) in response to a request from the treating practitioner or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or
- (ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

#### ***Provision of Service***

The following conditions relate to provision of services:

- (i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;
- (ii) the service has to be provided in a pathology laboratory accredited for that kind of service;
- (iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;
- (iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and
- (v) no fee will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

### ***Therapeutic Goods Act 1989***

For any service listed in this schedule to be eligible for payment, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Approved Pathology Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of pathology services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

## **P.1.2. Exemptions to Basic Requirements**

### ***Prescribed Pathology Services***

A prescribed pathology service is a service included in Group P9 of the Pathology Services Table. Group P9 contains 11 services which may be performed by a medical practitioner in his or her own surgery on his or her own patients.

Additionally, fees are payable only where the service is determined to be necessary by the medical practitioner rendering the service, or is in response to a request by a member of a group of practitioners to which that practitioner belongs.

### ***Services Where Request Not Required***

A written request is not required for -

- (i) a prescribed pathology service rendered by or on behalf of a medical practitioner upon his or her own patients;
- (ii) a pathologist-determinable service. A pathologist-determinable service is a pathology service :
  - (a) that is specified rendered by or on behalf of an Approved Pathology Provider for a person who is a patient of that Approved Pathology Provider who has determined that the service is necessary; or
  - (b) that is specified in only one of immunohistochemistry items 72846, 72847 or 72848 or immunocytochemistry items 73059, 73060 or 73061 or electronmicroscopy items 72851 or 72852 and is considered necessary by the Approved Pathology Provider as a consequence of information

resulting from a pathology service contained in tissue examination items 72813 – 72836, cytology items 73045 – 73051 or tissue examination items 72813 - 72836 respectively. Please note: a written request is required for a service contained in items 72813 to 72836 and items 73045 to 73051.

- (c) that is specified in one of the antigen detection items 69494, 69495 or 69496 is considered necessary by the specialist pathologist as a consequence of information provided by the requesting practitioner or by the nature or appearance of the specimen or as a consequence of information resulting from a pathology service contained in items 69303, 69306, 69312, 69318, 69321, 69345. Please note: a written request is required for a service contained in items 69303, 69306, 69312, 69318, 69321, 69345 or for a service contained in items 69494, 69495 or 69496.
- (d) that is specified in item 73320, HLA-B27 typing by nucleic acid amplification, and is considered necessary by the specialist pathologist because the results of HLA-B27 typing described in item 71147 are unsatisfactory.

### **P.1.3. Circumstances Where WorkCover fees are Not Attracted**

#### ***Services Rendered by Disqualified Practitioner***

Fees are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that fees should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

#### ***Certain Pathology Tests Do Not Attract WorkCover fees***

Certain tests of public health significance do not qualify for payment. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of
- disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed.

In addition to the above, certain other tests do not qualify for payment. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures;
- pathology services performed on stillborn babies or cadavers;
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services.

However, fees will be paid for the following pathology tests:

- item 65060 - haemoglobin estimation;
- item 65090 - blood grouping ABO and Rh (D antigen);
- item 65096 - examination of serum for Rh and other blood group antibodies.

### **P.2.1. Responsibilities of Treating/Requesting Practitioners**

#### ***Form of Request***

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners must be in accordance with the Medicare Australia approved form. Written pathology requests from treating practitioners that are not on a form prepared and distributed by a pathologist do not need to be approved. However, all written requests for pathology services should contain the following particulars:

- (i) the individual pathology services, or recognised groups of pathology tests to be rendered. The description must be sufficient to enable the item in which the service is specified to be identified;
- (ii) the date of request;
- (iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;
- (iv) the patient's name and address;
- (v) details of the hospital status of the patient, as follows. That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:
  - (a) a private patient in a private hospital, or approved day hospital facility;
  - (b) a private patient in a recognised hospital;
  - (c) a public patient in a recognised hospital;
  - (d) an outpatient of a recognised hospital;

- (vi) details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Practitioner or an Approved Pathology Authority. If the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority. If the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

## **P.2.2. Responsibilities of Approved Pathology Practitioners**

### ***Form of Request***

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made. Written requests are to be in the form as set out by Medicare Australia.

### ***Holding, Retention, Recording and Production of Request Forms***

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients or WorkCover. An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Ageing, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

### ***Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner***

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

- (i) where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner;
- (ii) where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed;

in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account or receipt:

- (a) name and provider number of the original requesting practitioner; and
- (b) date of original request;

- (iii) under the item coning rules (which limit fees for multiple services) only one fee is payable for services included in coned items except for estimations covered by Rule 6 entitled "designated pathology services". The exemption allows payment of more than one fee where various components of the one item number from the same request e.g. drug assays (items 66800 and 66812) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in Rule 6 permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the fee payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:

- (i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;
- (ii) photocopies of requests are not acceptable;
- (iii) in the case of "designated pathology services" 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165 a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

### **P.2.3. Pathology Tests not Covered by Request**

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract fees providing the Approved Pathology Practitioner is a recognised specialist pathologist.

### **P.3.1. Details Required on Accounts, Receipts or Assignment Forms**

#### **General**

Fees are not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

### **P.3.2. Approved Pathology Practitioners**

An approved pathology practitioner is one who Medicare Australia recognises as an approved pathology practitioner. In addition to holding a request in writing from the treating medical or dental practitioner or from

another Approved Pathology Practitioner, the following additional details must be recorded on the account or receipt of the Approved Pathology Practitioner providing the service:

- (i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;
- (ii) the name of the person to whom the service was rendered;
- (iii) the date on which the service was rendered;
- (iv) the name of the requesting practitioner; or in the case of a referred test, the name of the original requesting practitioner;
- (v) the date on which the request was made; or in the case of a referred test, the date on which the original request was made;
- (vi) the requesting practitioner's provider number;
- (vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered;
- (viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and
- (ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account or receipt must be identical to those of the original requesting practitioner including the date of request.

### **P.3.3. Pathology Services**

For Pathology Services, the medical practitioner who renders the service must ensure his or her account or receipt includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

#### **P.4.1. Inbuilt Multiple Services Rule**

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the fees payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode.

#### **P.4.2. Exemptions**

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 6 times over a 24 hour

period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate fees. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

### **P.5.1. Episode Cone**

#### **Description of Rule 18**

The term "Episode Cone" describes an arrangement under which fees payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the fees for the three items with the highest Schedule fees.

### **P.5.2. Exemptions**

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items identified in Rule 18.(1)(d) and (e).

### **P.6.2. Patient Episode Initiation Fees (PEIs)**

Items in Groups P10 of the Pathology Services Table are only applicable to services performed:

- (i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and
- (ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a privately referred out-patient of a recognised hospital.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, fees will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 14.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 14.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

- a tissue pathology specimen and any other non-tissue pathology specimen; or
- a cytopathology specimen and any other non-cytopathology specimen.

Rule 14.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

**P.6.3. Patient Episode Initiation Fees for Certain Tissue Pathology and Cytology Items**

Tissue Pathology items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 and Cytology items 73053, 73055 and 73057 will be subject to a different patient episode initiation fee structure - items 73922 to 73939 refer.

**P.6.4. Hospital, Government etc Laboratories**

The following laboratories have been prescribed for the purposes of payment of fees:

- (i) laboratories operated by the Australian Government (these include health laboratories operated by the Australian Government Department of Health and Ageing as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);
- (ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);
- (iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and
- (iv) laboratories operated by Australian tertiary education institutions eg Universities.

**P.7.2. Approved Pathology Practitioner Eligibility**

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive payments. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive the fee for the service in question.

**P.8.1. Accredited Pathology Laboratories - Need for Accreditation**

A pathology service will not attract fees unless that service is provided in a pathology laboratory which is accredited for that kind of service by Medicare Australia.

**P.10.1. Approved Pathology Authorities****Introduction**

A pathology service will not attract fees unless the proprietor of the laboratory in which the pathology service is performed has been approved by Medicare Australia.

**P.15.1. Definitions****Excessive Pathology Service**

This means a pathology service for which a fee has become or may become payable and which is not reasonably necessary for the medical or dental care of the patient concerned.

**P.15.2. Group of Practitioners**

This means:

- (i) a practitioner conducting a medical practice or a dental practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or
- (ii) two or more practitioners conducting a medical practice or a dental practice as partners; or
- (iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

### **P.15.3. Initiate**

In relation to a pathology service this means to request the provision of pathology services for a patient.

### **P.15.4. Patient Episode**

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode.

Rule 14.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

### **P.15.5. Episode Cone**

The episode cone is an arrangement, described in Rule 18, which effectively places an upper limit on the number of items for which fees are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the fees payable will be equivalent to the sum of the fees for the three items with the highest Schedule fees. Rule 18 provides that for the two items with the highest Schedule fees, fees will be payable for each item. The remaining items are regarded as one service for which the fee payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:

- (i) all the items in Groups P10, P11, P12 and P13;
- (ii) Pap smear testing (items 73053 and 73055);
- (iii) designated pathology services as detailed at Rule 18 (e) (items 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318); and
- (iv) supplementary test for Hepatitis B and Hepatitis C (item 69484).

#### **P.15.6. Personal Supervision**

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services.

#### **P.15.7. Prescribed Pathology Service**

These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

#### **P.15.8. Proprietor of a Laboratory**

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:

- (i) the laboratory premises, whether or not the holder of an estate or interest in the premises;
- (ii) the use of equipment used in the laboratory; and
- (iii) the employment of staff in the laboratory.

#### **P.15.9. Specialist Pathologist**

This means a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist in pathology. The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

#### **P.15.10. Designated Pathology Service**

This means a pathology service specified in items 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 65150, 65175, 66650, 66695, 66711, 66722, 66785,

66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

**P.16.1. Interpretation of The Schedule - Items Referring to 'The Detection Of'**

Items that contain the term 'detection of' should be taken to mean 'testing for the presence of'.

**P.16.2. Blood Grouping - (Item 65096)**

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

**P.16.3. Glycosylated Haemoglobin - (Item 66551)**

The requirement of "established diabetes" in this item may be satisfied by:

- (a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or
- (b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or
- (c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

**P.16.4. Iron Studies - (Item 66596)**

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

**P.16.5. Faecal Occult Blood - (Items 66764 to 66770)**

**P.16.6. Antibiotics/Antimicrobial Chemotherapeutic Agents**

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66800 or 66812 - 'quantitation of a drug being used therapeutically'.

**P.16.7. Human Immunodeficiency Virus (HIV) Diagnostic Tests - (included in Items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413 and 69415)**

Prior to ordering an HIV diagnostics tests (included in items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413, 69415) the ordering practitioner should ensure that the patient has given informed consent. Appropriate discussion should be provided to the patient. Further discussion may be necessary upon receipt of the test results.

**P.16.8. Hepatitis - (Item 69481)**

Fees for item 69481 are payable only if the request from the ordering practitioner indicates in writing that the patient is suspected of suffering from acute or chronic hepatitis; either by the use of the provisional diagnosis of hepatitis or by relevant clinical or laboratory information eg "hepatomegaly", "jaundice" or "abnormal liver function tests".

**P.16.9. Eosinophil Cationic Protein - (Item 71095)**

Item 71095 applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

**P.16.10. Tissue Pathology and Cytology - (Items 72813 to 73061)**

When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

**P.16.11. Cervical and Vaginal Cytology - (Items 73053 to 73057)**

Item 73053 applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. This item also applies to smears repeated due to an unsatisfactory routine smear, or if there is inadequate information provided to use item 73055.

Cytological examinations carried out under item 73053 should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:

- (i) an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later; and
- (ii) cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The screening policy will not be used as a basis for determining eligibility for fees. However, the policy will be used as a guide for reviewing practitioner profiles.

Item 73055 applies to cervical cytological examinations where the smear has been collected for the purpose of management, follow up or investigation of a previous abnormal cytology report, or collected from women with symptoms, signs or recent history suggestive of abnormal cervical cytology.

Items 73057 applies to all vaginal cytological examinations, whether for a routine examination or for the follow up or management of a previously detected abnormal smear.

For cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, by item number, if the smear has been taken as a routine examination or for the management of a previously detected abnormality.

**P.16.12. Fragile X (A) Tests - (Items 73300 and 73305)**

Prior to ordering these tests (73300 and 73305) the ordering practitioner should ensure the patient has given informed consent. Appropriate genetic counselling should be provided to the patient either by the treating

practitioner, a genetic counselling service or by a clinical geneticist on referral. Further counselling may be necessary upon receipt of the test results.

**P.16.14. Transfer of Existing Items from Group P1 (Haematology) to Group P7 Genetics Effective 1 May 2006.**

P16.14 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 (Chemistry) to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

**P.17.1. Abbreviations, Groups of Tests**

As stated at P3.2 of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and
- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

**P.17.2. Tests not Listed**

Tests which are not listed in the Pathology Services Table do not attract fees.

**P.17.4. Groups of Tests**

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item. These groups exclude abbreviations such as MBA and TORCH.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract fees.

Group	Estimations included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes or cardiac markers	Creatine kinase isoemzymes, Myoglobin, Troponin	CE / CM	66518, 66519
Coagulation studies	Full blood count, Prothrombin time, Activated partial thromboplastin time and two or more of the following tests – Fibrinogen, Thrombin, Clotting time, Fibrinogen degradation products, Fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA), Potassium (K), Chloride (CL) and Bicarbonate (HCO <sub>3</sub> )	E	66509
Full Blood Examination	Erythrocyte count, Haematocrit, Haemoglobin, Platelet count, Red cell count, Leucocyte count, Manual or instrument generated differential, Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and Triglycerides (TRIG)	FATS	66503
Liver function tests	Alkaline phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Albumin (ALB), Bilirubin (BIL), Gamma glutamyl transpeptidase (GGT), Lactate dehydrogenase (LDH), and Protein (PROT)	LFT	66512
Syphilis serology	Rapid plasma regain test (RPR), or Venereal disease research laboratory test (VDRL), and Treponema pallidum haemagglutinin test (TPHA), or Fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, Electrolytes, Creatinine	Urea, Electrolytes, Creatinine	U&E	66512

### P.18.1. Complexity Levels for Histopathology Items

Only one of these histopathology examination items (72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830, 72836 and 72838) can be claimed in a patient episode.

The remaining items (72844, 72846, 72847, 72848, 72851, 72852, 72855, 72856 and 72857) are add-on items, covering enzyme histochemistry and immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item.

The list of complexity levels by type of specimen are contained at the back of this Section.

### P.19.1. Pathology Services Table

#### Rules for the Interpretation of the Pathology Services Table

1. (1) In this table

**patient episode** means:

- (a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under relevant Commonwealth, State and Territory laws:
  - (i) on the same day; or
  - (ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days; whether the services:
  - (iii) are requested by 1 or more practitioners; or
  - (iv) are described in a single item or in more than 1 item; or
  - (v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or
  - (vi) are rendered on the same or different days; or
- (b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

**receiving APP** means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

**recognised pathologist** means a medical practitioner recognised as a specialist in pathology in accordance with the Health Practitioner Regulation National Law or any other authorising body and who appears on the Medical Board of Australia specialist register, excluding general practitioners.

**referring APP** means an approved pathology practitioner in an approved pathology authority who:

- (i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; and
- (ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the pathology services; and
- (iii) requests an approved pathology practitioner (the **receiving APP**) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and
- (iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

**serial examinations** means a series of examinations requested on 1 occasion whether or not:

- (a) the materials are received on different days by the approved pathology practitioner; or
- (b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

**the Act** means the *Health Insurance Act 1973*.

1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.
1. (3) A reference in this table by number to an item that is not included in this table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.
1. (4) A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

### Precedence of items

2. (1) If a service is described:
  - (a) in an item in general terms; and
  - (b) in another item in specific terms;
 only the item that describes the service in specific terms applies to the service.
2. (2) Subject to subrule (3), if:
  - (a) subrule (1) does not apply; and
  - (b) a service is described in 2 or more items;
 only the item that provides the lower or lowest fee for the service applies to the service.
2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.
5. (1) For an item in Group P1 (Haematology):
  - (a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and
  - (b) if:
    - (i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and
    - (ii) specimen material from the patient episode is stored; and
    - (iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material;
 the later tests and the earlier tests are taken to be part of one patient episode.
5. (2) Fees for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5. (3) For items 65099 and 65102:

**compatibility tests by crossmatch** means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

**Certain items not to apply to a service referred by one pathology practitioner to another**

6. (1) In this rule:

**designated pathology service** means a pathology service in respect of tests relating to a single patient episode that are tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

6. (2) This rule applies in respect of a designated pathology service where:

- (a) an approved pathology practitioner (**practitioner A**) in an approved pathology authority:
  - (i) has been requested to render the designated pathology service; and
  - (ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the tests included in the service; and
  - (iii) requests an approved pathology practitioner (**practitioner B**) in another approved pathology authority to render the test or tests that practitioner A is unable to render; and
  - (iv) renders each test (if any) included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made; and
- (b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 65156, 65179, 66653, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69496, 71093, 71159 or 71168.

6. (3) If this rule applies in respect of a designated pathology service:

- (a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and
- (b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) and:
  - (i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or
  - (ii) practitioner A has not rendered any of the tests that the service comprises -
    - (A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and

(B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

- (a) for item 66652, 66715, 66790, 66817, 66821 or 66827: 2 – X; and
- (b) for item 65158, 66805, 69498 or 71092: 3 – X; and
- (c) for item 71156 or 71170: 4 – X; and
- (d) for item 65181 or 66724: 5 – X; and

where X is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second mentioned approved pathology practitioner in subrule (2).

#### Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

#### Creatinine ratios – Group P2 (chemical)

8. A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:

- (a) involves the measurement of a substance in urine; and
- (b) requires calculation of a substance/creatinine ratio;

is taken to include the measurement of creatinine necessary for the calculation.

#### Thyroid function testing

9. (1) For item 66719:

**abnormal level of TSH** means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

9. (3) The written statement from the medical practitioner must indicate:

- (a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or

- (b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
- (c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

**Meaning of "serial examinations or cultures"**

10. For an item in Group P3 (Microbiology):

- (a) **serial examinations or cultures** means a series of examinations or cultures requested on 1 occasion whether or not:
  - (i) the materials are received on different days by the approved pathology practitioner; or
  - (ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and
- (b) if:
  - (i) tests are carried out in relation to a patient episode; and
  - (ii) specimen material from the patient episode is stored; and
  - (iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

**Investigation for hepatitis serology**

11. A fee is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

**Tests in Group P4 (Immunology) relating to antibodies**

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

- (a) tests are carried out in relation to a patient episode; and
- (b) specimen material from the patient episode is stored; and
- (c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

**Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)**

13. (1) For items in Group P5 (Tissue pathology):

- (a) **biopsy material** means all tissue received by the Approved Pathology Practitioner:
  - (i) from a medical procedure or group of medical procedures performed on a patient at the same time; or
  - (ii) after being expelled spontaneously from a patient.

- (b) **cytology** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and
- (c) **separately identified specimen** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.
- 13. (2)** For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.
- 13. (3)** For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.
- 13.(4)** If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.
- 13.(5)** If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a fee is payable only for the examination that has the highest schedule fee.
- 13.(6)** In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 a reference to a **complexity level** is a reference to the level given to a specimen type mentioned in Part 5 of this Table.
- 13.(7)** If more than 1 of the services mentioned in items 72846, 72847, 72848; 72849 and 72850 or 73059, 73060, 73061, 73064 and 73065 are performed in a single patient episode, a fee is payable only for the item performed that has the highest scheduled fee.
- 14. (2)** If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:
- (a) the service is rendered upon a request made in the course of a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.
- 14. (3)** An item in Group P10 or P11 does not apply to a pathology service.
- 14. (4)** An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.
- 14. (5)** Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in the Group applies to the patient episode.
- 14. (6)** An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

**14. (7)** If, in respect of the same patient episode:

- (a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or
- (b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;

the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

**14. (8)** If more than one specimen is collected from a person on the same day for the provision of pathology services:

- (a) in accordance with more than 1 request; and
- (b) in or by a single approved pathology authority;

the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 "S4B(3)".

**14. (9)** The amount specified in item 73940 is payable only once in respect of a single patient episode.

**Application of an item in Group P11 (Specimen referred) to a service excludes certain other items**

**15.** If item 73940 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73940 in respect of the patient episode.

**Circumstances in which an item in Group P11 (Specimen referred) does not apply**

**16. (1)** An item in Group P11 does not apply to a referral if:

- (a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and
- (b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.

**16. (2)** An approved pathology authority is **related to** another approved pathology authority for subrule (1) if:

- (a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or
- (b) either of the approved pathology authorities is employed (including employed under contract) by the other; or
- (c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or

- (d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or
- (e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or
- (f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

**16. (3)** An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66536, 66596, 69300, 69303, 69333 or 73527.

### Abbreviations

**17. (1)** The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

**17. (2)** The names of services or drugs not listed in Part 4 of this table must be written in full.

### Certain pathology services to be treated as 1 service

**18. (1) In this rule:**

***general practitioner*** means a medical practitioner who:

- (a) is not a consultant physician in any specialty; and
- (b) is not a specialist in any specialty.

***set of pathology services*** means a group of pathology services:

- (a) that consists of services that are described in at least 4 different items; and
- (b) all of which are requested in a single patient episode; and
- (c) each of which relates to a patient who is not an admitted patient of a hospital; and
- (d) excludes services referred to in an item in Group P10, Group P11, Group P12 or Group P13, items 69484, 73053 and 73055; and
- (e) excludes services described in the following items:  
65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 66832, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318, 73321 and 73324;

where those services are performed by an approved pathology practitioner in an accredited

pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.

- (1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).
- 18. (2)** If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.
- 18. (3)** If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
- (a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and
  - (b) either:
    - (i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or
    - (ii) if 2 or more items that describe any of those services specify the second-highest fee — the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
  - (c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.
- 18. (4)** If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
- (a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
  - (b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and
  - (c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.
- 18. (5)** If pathology services are to be treated as 1 pathology service under paragraph (3) (c) or (4) (c), the fee for the 1 pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

### **Hepatitis C viral RNA testing**

- 19.** For item 69499 and 69500:

***Hepatitis C sero-positive***, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

***serological status is uncertain***, for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

### **Haemochromatosis testing**

20. For items 73317 and 73318:

***elevated serum ferritin*** for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

### **Serum B12 and red cell folate testing**

21. (1) For items 66599 and 66602, a fee is not payable for more than 3 episodes of services described in item 66599 or 66602, or any combination of those items, in a 12 month period.

21. (2) A fee is not payable for a service described in item 66599 if the service was provided as part of the same patient episode as a service described in item 66602.

### **Nutritional and toxicity metals testing**

22. (1) For this rule:

***nutritional metals testing group*** means items 66819, 66820, 66821 and 66822.

***metal toxicity testing group*** means items 66825, 66826, 66827, 66828, 66831 and 66832.

22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if fees are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:

- (a) that item; or
- (b) the other item in the same group; or
- (c) an item in the other group.

### **Antineutrophil Cytoplasmic Antibody**

23. A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

### **Satisfying Requirements Described in Items**

24. Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:

- (a) The requirement/s as stipulated in the item descriptor are contained in the request form; or
- (b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the Approved Pathology Authority (APA) and this documentation is retained by the APA; or

- (c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or
- (d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or

The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

**Limitation on certain items**

- 25. (a) For any particular patient, items 66539, 66605, 66607, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.
- (b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.
- (c) For any particular patient, items 66655, 66659, 69482, 69491, 69499 or 69500 are applicable not more than once in a 12 month period.
- (d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.
- (e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.
- (f) For any particular patient, items 66551, 66660, 69445, 69451, 69483, 71079 or 73523 are applicable not more than 4 times in a 12 month period.
- (g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.
- (h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.
- (i) For any particular patient, items 69418 and 69419 are applicable not more than twice in a 24 month period.

**Antigen Detection – Group P3 (Microbiology)**

- 26. If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.
- 27. If the service rendered in 71148, 73320 or 73321 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

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