

Medicare Benefits Schedule

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G1.1 The Medicare Benefits Schedule - Introduction

Schedules of Services

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

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

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 specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

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

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

Explanatory Notes

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

G1.2 Medicare - an outline

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

- (a) Free treatment for public patients in public hospitals.
- (b) The payment of 'benefits', or rebates, for professional services listed in the Medicare Benefits

Schedule (MBS). In general, the Medicare benefit is 85% of the Schedule fee, otherwise the benefits are

- i. 100% of the Schedule fee for services provided by a general practitioner to non-referred, non-admitted patients;
- ii. 100% of the Schedule fee for services provided on behalf of a general practitioner by a practice nurse or registered Aboriginal Health Worker;
- iii. 75% of the Schedule fee for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients);
- iv. 75% of the Schedule fee for professional services rendered as part of a privately insured episode of hospital-substitute treatment.

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

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

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

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

G1.3 Medicare benefits and billing practices

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

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

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

G2.1 Provider eligibility for Medicare

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

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

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

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

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

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

Non-medical practitioners

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

- (a) registered according to State or Territory law or, absent such law, be members of a professional association with uniform national registration requirements; and
- (b) registered with Medicare Australia to provide these services.

G2.2 Provider Numbers

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

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

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

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

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

G2.3 Locum tenens

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

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

- (a) they are an approved general practice or specialist trainee with a provider number issued for an approved training placement; or
- (b) they are associated with an approved rural placement under Section 3GA of the *Health Insurance Act 1973*; or
- (c) they have access to Medicare benefits as a result of the issue of an exemption under section 19AB of the *Health Insurance Act 1973* (i.e. they have access to Medicare benefits at specific practice locations); or
- (d) they will be at a practice which is participating in the Practice Incentives Program; or
- (e) they are associated with a placement on the MedicarePlus for Other Medical Practitioners (OMPs) program, the After Hours OMPs program, the Rural OMPs program or Outer Metropolitan OMPs program.

G2.4 Overseas trained doctor

Ten year moratorium

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

- (a) their date of registration as a medical practitioner for the purposes of the *Health Insurance Act*

1973; *or*

(b) their date of permanent residency (the reference date will vary from case to case).

Exclusions - Practitioners who before 1 January 1997 had

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

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

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

G2.5 Addresses of Medicare Australia, Schedule Interpretation and Changes to Provider Details

NEW SOUTH WALES Medicare Australia Paramatta Office 130 George Street PARRAMATTA NSW 2150	VICTORIA Medicare Australia Melbourne Office Level 10 595 Collins Street MELBOURNE VIC 3000	QUEENSLAND Medicare Australia Brisbane Office 143 Turbot Street BRISBANE QLD 4000
SOUTH AUSTRALIA Medicare Australia Adelaide Office 209 Greenhill Road EASTWOOD SA 5063	WESTERN AUSTRALIA Medicare Australia Perth Office Level 4 130 Stirling Street PERTH WA 6003	TASMANIA Medicare Australia Hobart Office 199 Collins Street HOBART TAS 7000

<p>NORTHERN TERRITORY</p> <p>As per South Australia</p>	<p>AUSTRALIAN CAPITAL TERRITORY</p> <p>Medicare Australia National Office</p> <p>134 Reed Street North</p> <p>GREENWAY ACT 2901</p>	
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Schedule Interpretations

The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of Medicare Australia. Inquiries concerning matters of interpretation of Schedule items should be directed to Medicare Australia and not to the Department of Health and Ageing. The following telephone numbers have been reserved by Medicare Australia exclusively for inquiries relating to the Schedule:

Provider Enquiries: 132 150

Public Enquiries: 132 011

Changes to Provider Details

It is important that Medicare Australia be notified promptly of changes to practice addresses to ensure correct provider details for each practice location. Changes to practice address details can be made in writing to the Medicare Australia office, listed above, in the State of the practice location.

G3.1 Patient eligibility for Medicare

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

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

G3.2 Medicare cards

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

families.

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

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

G3.3 Visitors to Australia and temporary residents

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

G3.4 Reciprocal Health Care Agreements

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

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

Exceptions:

- Visitors from Ireland and New Zealand are entitled to public hospital care and PBS drugs, and should present their passports before treatment as they are not issued with Medicare cards.
- Visitors from Italy and Malta are covered for a period of six months only.

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

G4.1 General Practice

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

- (a) vocationally registered under section 3F of the *Health Insurance Act 1973* (see General Explanatory Note below); or
- (b) a Fellow of the Royal Australian College of General Practitioners (FRACGP), who participates in, and meets the requirements for the RACGP Quality Assurance and Continuing Medical Education Program; or
- (c) a Fellow of the Australian College of Rural and Remote Medicine (FACRRM) who participates in, and meets the requirements for the ACRRM Quality Assurance and Continuing Medical Education Program; or
- (d) is undertaking an approved general practice placement in a training program for *either* the award of FRACGP *or* a training program recognised by the RACGP being of an equivalent standard; or
- (e) is undertaking an approved general practice placement in a training program for *either* the award of FACRRM *or* a training program recognised by ACRRM as being of an equivalent standard.

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

Vocational recognition of general practitioners

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

- (a) certification by the RACGP that the practitioner
 - is a Fellow of the RACGP; and
 - practice is, or will be within 28 days, predominantly in general practice; and
 - has met the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance programs.
- (b) certification by the General Practice Recognition Eligibility Committee (GPREC) that the practitioner
 - is a Fellow of the RACGP; and
 - practice is, or will be within 28, predominantly in general practice; and
 - has met minimum requirements of the RACGP for taking part in continuing medical

education and quality assurance programs.

- (c) certification by ACRRM that the practitioner
- is a Fellow of ACRRM; and
 - has met the minimum requirements of the ACRRM for taking part in continuing medical education and quality assurance programs.

In assessing whether a practitioner's medical practice is predominantly in general practice, the practitioner must have at least 50% of clinical time and services claimed against Medicare. Regard will also be given as to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

Further information on eligibility for recognition should be directed to:

Program Relations Officer, RACGP

Tel: (03) 8699 0494 Email at: qacpd@racgp.org.au

Secretary, General Practice Recognition Eligibility Committee:

Tel: (02) 6124 6753 Email at co.medicare.eligibility@medicareaustralia.gov.au

Executive Assistant, ACRRM:

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

How to apply for vocational recognition

Medical practitioners seeking vocational recognition should apply to Medicare Australia using the approved Application Form available on the Medicare Australia website: www.medicareaustralia.gov.au. Applicants should forward their applications, as appropriate, to

Chief Executive Officer

The Royal Australian College of General Practitioners

College House

1 Palmerston Crescent

SOUTH MELBOURNE VIC 3205

Chief Executive Officer

Australian College of Rural and Remote Medicine

GPO Box 2507

BRISBANE QLD 4001

Secretary

The General Practice Recognition Eligibility Committee

Medicare Australia

PO Box 1001

TUGGERANONG ACT 2901

The relevant body will forward the application together with its certification of eligibility to the Medicare Australia CEO for processing.

Continued vocational recognition is dependent upon:

- (a) the practitioner's practice continuing to be predominantly in general practice (for medical practitioners in the Register only); and
- (b) the practitioner continuing to meet minimum requirements for participation in continuing professional development programs approved by the RACGP or the ACRRM.

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

Medical practitioners refused certification by the RACGP, the ACRRM or GPREC may appeal in writing to the General Practice Recognition Appeal Committee (GPRAC), Medicare Australia, PO Box 1001, Tuggeranong, ACT, 2901.

Removal of vocational recognition status

A medical practitioner may at any time request Medicare Australia to remove their name from the

Vocational Register of General Practitioners.

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

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

G5.1 Recognition as a Specialist or Consultant Physician

A medical practitioner who:

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a specified specialist College and has obtained, after successfully completing an appropriate course of study, a relevant qualification from a relevant College

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

A relevant specialist College may also give Medicare Australia's Chief Executive Officer a written notice stating that a medical practitioner meets the criteria for recognition.

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

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

Further information about applying for recognition is available at www.medicareaustralia.gov.au.

G5.2 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.

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

G6.1 Referral Of Patients To Specialists Or Consultant Physicians

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

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

What is a Referral?

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

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

- (i) the referring practitioner must have undertaken a professional attendance with the patient and turned his or her mind to the patient's need for referral and have communicated relevant

information about the patient to the specialist or consultant physician (this need not mean an attendance on the occasion of the referral);

- (ii) the instrument of referral must be in writing as a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
- (iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

The exceptions to the requirements in paragraph above are that

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

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

(b) subparagraphs (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) subparagraph (iii) does not apply to instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

Examination by Specialist Anaesthetists

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

Who can Refer?

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

Referrals are to be made as follows:-

- (a) to a recognised consultant physician
 - (i) by another medical practitioner; or
 - (ii) by an approved dental practitioner¹ (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 ², where the referral arises out of a dental service; or
- (iii) by a registered optometrist where the specialist is an ophthalmologist.

¹ See paragraph OB.1 for the definition of an approved dental practitioner.

² 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, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergencies

If the referral occurred in an emergency, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance.

For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.

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

Public Hospital Patients

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

Bulk Billing

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

Period for which Referral is Valid

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

Specialist Referrals

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

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

Referrals by other Practitioners

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

Definition of a Single Course of Treatment

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

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

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

However, where the referring practitioner:-

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

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

Retention of Referral Letters

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

A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 18 months from the date the service was rendered.

A specialist or a consultant physician is required, if requested by the Medicare Australia CEO, to produce to a medical practitioner who is an employee of Medicare Australia, the instrument of referral within

seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

Attendance for Issuing of a Referral

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

Locumtenens Arrangements

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

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

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

Self Referral

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

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

For Medicare benefit purposes, a referral may be made to

- (i) a recognised specialist:
 - (a) by a registered dental practitioner, where the referral arises from a dental service; or
 - (b) by a registered optometrist where the specialist is an ophthalmologist; or
 - (c) by a participating midwife where the specialist is an obstetrician or a paediatrician, as clinical needs dictate. A referral given by a participating midwife is valid until 12 months after the

first service given in accordance with the referral and for I pregnancy only or

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

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

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

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

G7.1 Billing procedures

Itemised Accounts

Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to claim Medicare benefits.

Under the provisions of the *Health Insurance Act 1973 and Regulations*, a Medicare benefit is not payable for a professional service unless it is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars

- i. patient's name;
- ii. the date the professional service was rendered;
- iii. the amount charged for the service;
- iv. the total amount paid in respect of the service;
- v. any amount outstanding in respect of the service;
- vi. for professional services rendered to a patient as part of an episode of hospital treatment; an asterisk '*' directly after an item number where used; or a description of the professional service sufficient to identify the item that relates to that service, preceded by the words 'admitted patient' ;
- vii. for professional services rendered as part of a privately insured episode of hospital-substitute treatment and the patient who receives the treatment chooses to receive a benefit from a private health insurer, the words 'hospital-substitute treatment' directly after an item number where used; or

a description of the professional service sufficient to identify the item that relates to that service, preceded by the words 'hospital-substitute treatment';

- viii. the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with Medicare Australia, the provider number used should be that which is applicable to the practice location at or from which the service was given);
- ix. the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:
 - a. for services in Groups A1 to A14, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillofacial services), and Group P9 of Pathology where the person claiming payment is NOT the person who rendered the service;
 - b. for services in Groups D2, T2, T3, I2, to I5 for every service;
- x. if the service was a Specified Simple Basic Pathology Test (listed in Category 6 Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;
- xi. where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and
- xii. where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred: (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number for that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

NOTE: If the information required to be recorded on accounts, receipts or assignment of benefit forms is included by an employee of the practitioner, the practitioner claiming payment for the service bears responsibility for the accuracy and completeness of the information.

Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

The *Private Health Insurance Act 2007* provides for the payment of private health insurance benefits for hospital treatment and general treatment. Hospital treatment is treatment that is intended to manage a disease, injury or condition that is provided to a person by a hospital or arranged with the direct involvement of a hospital. General treatment is treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment. Hospital-substitute treatment is a sub-set of General Treatment and a direct substitute for an episode of hospital treatment. Health insurers can cover specific professional services as hospital-substitute treatment in accordance with the *Private Health Insurance (Health Insurance Business) Rules*.

Claiming of Benefits

The patient, upon receipt of a doctor's account, has three courses open for paying the account and receiving benefits.

Paid Accounts

The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.

In these circumstances, where a claimant personally attends a Medicare office to obtain a cash or EFT deposit for the payment of Medicare benefits, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

A Medicare patient claim form (PC1) must be completed where the claimant is mailing his/her claim for a cheque or EFT payment of Medicare benefits or arranging for an agent to collect cash on the claimant's behalf at a Medicare office.

Alternatively a patient may lodge their claim electronically from the doctors' surgery using Medicare Australia's Online claiming.

Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer of the patient will forward the claim to Medicare Australia for the payment of Medicare benefits

Unpaid and Partially Paid Accounts

Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the doctor.

It will be the patient's responsibility to forward the cheque to the doctor and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits, must (by law), not be sent direct to medical practitioners or to patients at a doctor's address (even when the claimant requests this). "Pay doctor" cheques are required to be forwarded to the claimant's last known address.

When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay

doctor" cheque the medical practitioner should indicate on the receipt that a "Medicare" cheque for \$..... was included in the payment of the account.

Where a patient has reached the relevant extended Medicare safety net threshold, the Medicare benefit payable is the Medicare rebate for the service plus 80% of the out-of-pocket cost of the service (ie difference between the fee charged by the doctor and the Medicare rebate). The patient must pay at least 20% of the out-of-pocket cost of the account before extended Medicare safety net benefits become payable for the out-of-pocket cost. Medicare will apportion the benefit accordingly.

Claims for professional services rendered as part of an episode of hospital-substitute treatment should be submitted to the health insurer in the first instance for the payment of private health insurance benefits. The insurer of the patient will forward the claim to Medicare Australia for the payment of Medicare benefits.

Assignment of Benefit (Direct - Billing) Arrangements

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

If a medical practitioner direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient, with the exception of certain vaccines.

Under these arrangements:

- the patient's Medicare number must be quoted on all directbill assignment forms for that patient;
- the assignment forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;

Where a patient is unable to sign the assignment form:

- the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable; or
- In the absence of a "responsible person" the patient signature section should be left blank.

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

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

Where the patient is direct-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96, 5000 to 5267 (inclusive) and item 10993 and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

Use of Medicare Cards in Direct Billing

The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the assignment forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

The patient details can, of course, be entered on the assignment forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

The Medicare card number must be quoted on assignment forms. If the number is not available, then the direct-billing facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

It is important for the practitioner to check the eligibility of patients to Medicare benefits by reference to the card, as enrollees have entitlement limited to the date shown on the card and some enrollees, eg certain visitors to Australia, have restricted access to Medicare (see paragraphs 3.4 and 3.5).

Assignment of Benefit Forms

To meet varying requirements the following types of stationery are available from Medicare Australia.

Note that these are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of Medicare Australia.

1. Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.
2. Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.
3. Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.
4. Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.
5. Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.
6. Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by Medicare Australia for that purpose.

The Claim for Assigned Benefits (Form DB1N, DB1H)

Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1N or DB1H. The DB1N form should be used where services are rendered to persons for treatment provided out of hospital or day hospital treatment. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and paygroup link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

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

The DB1N and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

DirectBill Stationery (Forms DB6Ba & DB6Bb)

Medical practitioners wishing to directbill may obtain information on directbill stationery by telephoning 132150.

- Form DB6Ba. This form is used to order larger stocks of forms DB3, DB4 and DB5 (and where a practitioner uses these forms, DB1N and DB1H), kits for optical scanning stationery (which comprises DB2's (GP, OP and OT)), DB1's pre addressed envelopes and an instruction sheet for the use of direct-bill scanning stationery.
- Form DB6Bb. This form is used to order stocks of forms and additional products (including Medicare Safety Net forms and promotional material). These forms are available from Medicare.

Time Limits Applicable to Lodgement of Claims for Assigned Benefits

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

Provision exists whereby in certain circumstances (eg hardship cases, third party workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

G8.1 Provision for review of individual health professionals

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

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

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

Following a review, the Director must:

decide to take no further action; or

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

refer the matter to a PSR Committee.

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

The Committee is authorized to:

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

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

require the production of documents (including clinical notes).

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

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

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

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

an unusual occurrence;

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

the characteristics of the patients.

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

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

Additional Information

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

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

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

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

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

G8.2 Medicare Participation Review Committee

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

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

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

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

G8.3 Referral of professional issues to regulatory and other bodies

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

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

G8.4 Medicare Benefits Schedule (MBS) - Quality Framework

The Government announced in the 2009-10 Budget that it would provide \$9.3 million over two years to develop and implement a new evidence-based framework for managing the MBS into the future - the MBS Quality Framework. The MBS Quality Framework will strengthen the listing, pricing and review processes that underpin the MBS by ensuring that services are aligned with contemporary clinical evidence, represent best value for money and improve health outcomes for patients.

Proposals for new MBS items or amendments to existing items

From 1 January 2010, proponents of all new MBS items that do not undergo an assessment through the Medical Services Advisory Committee (MSAC) and amendments to existing MBS items will be required to provide detailed information regarding the proposed service and its evidence base.

The Department will replace the informal internal assessment of all new MBS item applications with a more formal process that determines eligibility for MBS listing and the appropriate assessment pathway - either the Medical Services Advisory Committee or the MBS Quality Framework.

These arrangements are being developed and finalised in consultation with relevant stakeholders.

Those interested in submitting an application can do so by either:

1. directly submitting an application to MSAC or the Quality Framework for assessment; or
2. submitting an Initial Assessment Application Form to determine the appropriate assessment pathway

Forms and guidelines are available from the following website www.health.gov.au/mbrtg.

G8.5 Medical Services Advisory Committee

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

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

For more information on the MSAC refer to their website - www.msac.gov.au or email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on (02) 6289 6811.

G8.6 Pathology Services Table Committee

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

G8.7 Medicare Claims Review Panel

There are MBS items which make the payment of Medicare benefits dependent on a 'demonstrated' clinical need. Services requiring prior approval are those covered by items 11222, 11225, 12207, 12215, 12217, 14124, 21965, 21997, 30214, 32501, 42771, 42783, 42786, 42789, 42792, 45019, 45020, 45528, 45557, 45558, 45559, 45585, 45586, 45588, 45639

Claims for benefits for these services should be lodged with Medicare Australia for referral to the National Office of Medicare Australia for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable Medicare Australia to determine the eligibility of the service for the payment of benefits.

Practitioners may also apply to Medicare Australia for prospective approval for proposed surgery.

Applications for approval should be addressed to:

The MCRP Officer

PO Box 1001

Tuggeranong ACT 2901

G9.1 Penalties and Liabilities

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

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

G10.1 Schedule fees and Medicare benefits

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

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.

As a general rule Schedule fees are adjusted on an annual basis, usually in November.

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

There are presently three levels of Medicare benefit payable:

(a) **75% of the Schedule fee:**

i. for professional services rendered to a patient as part of an episode of hospital treatment (other than public patients). Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing an asterisk '*' directly after an item number where used; or a description of the professional service, preceded by the word 'patient';

ii. for professional services rendered as part of an episode of hospital-substitute treatment, and the patient who receives the treatment chooses to receive a benefit from a private health insurer. Medical practitioners must indicate on their accounts if a medical service is rendered in these circumstances by placing the words 'hospital-substitute treatment' directly after an item number where used; or a description of the professional service, preceded by the words 'hospital-substitute treatment'.

(b) **100% of the Schedule fee** for non-referred attendances by general practitioners to non-admitted patients and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

(c) **85% of the Schedule fee**, or the Schedule fee less \$71.20 (indexed annually), whichever is the greater, for all other professional services.

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

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

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

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

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

G10.2 Medicare safety nets

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

Original Medicare Safety Net:

Under the original Medicare safety net, the Medicare benefit for out-of-hospital services is increased to 100% of the Schedule Fee (up from 85%) once an annual threshold in gap costs is reached. Gap costs refer to the difference between the Medicare benefit (85%) and the Schedule Fee. The threshold from 1 January 2011 is \$399.60. This threshold applies to all Medicare-eligible singles and families.

Extended Medicare Safety Net:

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

In 2011, the threshold for singles and families that hold Commonwealth concession card, families that received Family Tax Benefit Part (A) (FTB(A)) and families that qualify for notional FTB(A) is \$578.60.

The threshold for all other singles and families is \$1,157.50.

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

Individuals are automatically registered with Medicare Australia for the safety nets; however couples and families are required to register in order to be recognised as a family for the purposes on the safety nets. In most cases, registered families have their expenses combined to reach the safety net thresholds. This may help to qualify for safety net benefits more quickly. Registration forms can be obtained from Medicare Australia offices, or completed online at www.medicareaustralia.gov.au.

EMSN Benefit Caps:

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

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

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

For example:

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

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

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

G11.1 Services not listed in the MBS

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

For example, intramuscular injections, aspiration needle biopsy, treatment of sebhorreic keratoses and less than 10 solar keratoses by ablative techniques and closed reduction of the toe (other than the great toe).

Enquiries about services not listed or on matters of interpretation should be directed to Medicare Australia on 132 150.

G11.2 Ministerial Determinations

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

G12.1 Professional services

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

The *Health Insurance Regulations 1975* specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously, although patients may be seen consecutively), unless a group session is involved (i.e. Items 170172). 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 170172, 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, benefits are payable only if the services have been conducted personally by the medical practitioner.

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

G12.2 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 Medicare benefits if the service is rendered by:

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

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

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

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

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

G12.3 Mass immunisation

Medicare benefits are payable for a professional attendance that includes an immunisation, provided that the actual administration of the vaccine is not specifically funded through any other Commonwealth or State Government program, nor through an international or private organisation.

The location of the service, or advertising of it, or the number of patients presenting together for it, normally do not indicate a mass immunisation.

G13.1 Services which do not attract Medicare benefits

Services not attracting benefits

- telephone consultations;
- 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 benefits.

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

- are paid/payable to a public hospital;
- are for a compensable injury or illness for which the patient's insurer or compensation agency has accepted liability. (Please note that if the medical expenses relate to a compensable injury/illness for which the insurer/compensation agency is disputing liability, then Medicare benefits are payable until the liability is accepted.);
- are for a medical examination for the purposes of life insurance, superannuation, a provident account scheme, or admission to membership of a friendly society;
- are incurred in mass immunisation (see General Explanatory Note 12 for further explanation).

Unless the Minister otherwise directs

Medicare benefits are not payable where:

- the service is rendered by or on behalf of, or under an arrangement with the Australian

Government, a State or Territory, a local government body or an authority established under Commonwealth, State or Territory law;

- the medical expenses are incurred by the employer of the person to whom the service is rendered;
- the person to whom the service is rendered is employed in an industrial undertaking and that service is rendered for the purposes related to the operation of the undertaking; or
- the service is a health screening service.
- the service is a pre-employment screening service

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

- (a) chelation therapy (that is, the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) other than for the treatment of heavy-metal poisoning;
- (b) the injection of human chorionic gonadotrophin in the management of obesity;
- (c) the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) the removal of tattoos;
- (e) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;
- (f) the removal from a cadaver of kidneys for transplantation;
- (g) the administration of microwave (UHF radio wave) cancer therapy, including the intravenous injection of drugs used in the therapy.

Pain pumps for post-operative pain management

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

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

Non Medicare Services

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

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

- (b) Endovenous laser treatment, for varicose veins;
- (c) Gamma knife surgery;
- (d) Intradiscal electro thermal arthroplasty;
- (e) Intravascular ultrasound (except where used in conjunction with intravascular brachytherapy);
- (f) Intro-articular viscosupplementation, for the treatment of osteoarthritis of the knee;
- (g) Low intensity ultrasound treatment, for the acceleration of bone fracture healing, using a bone growth stimulator;
- (h) Lung volume reduction surgery, for advanced emphysema;
- (i) Photodynamic therapy, for skin and mucosal cancer;
- (j) Placement of artificial bowel sphincters, in the management of faecal incontinence;
- (k) Sacral nerve stimulation, for urinary incontinence;
- (l) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
- (m) Specific mass measurement of bone alkaline phosphatase;
- (n) Transmyocardial laser revascularisation;
- (o) Vertebral axial decompression therapy, for chronic back pain.

Health Screening Services

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

- multiphasic health screening;
- mammography screening (except as provided for in Items 59300/59303);
- testing of fitness to undergo physical training program, vocational activities or weight reduction programs;
- compulsory examinations and tests to obtain a flying, commercial driving or other licence;
- entrance to schools and other educational facilities;
- for the purposes of legal proceedings;
- compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

- a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a Papanicolaou test in a woman (see General Explanatory note 13.6.4 for more information), blood lipid estimation where a person has a family history of lipid disorder. However, such routine check up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;
- a medical examination being a condition of child adoption or fostering;
- a medical examination being a requisite for Social Security benefits or allowances;
- a medical or optometrical examination provided to a person who is an unemployed person (as defined by the *Social Security Act 1991*), as the request of a prospective employer.

The National Policy on screening for the Prevention of Cervical Cancer (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) is as follows:-

- 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 or two years after first sexual intercourse, whichever is later;
- 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.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.11 of Pathology Services Explanatory Notes in Category 6).

Note 2: See items 2501 to 2509, and 2600 to 2616 in Group A18 and A19 of Category 1 - Professional

Attendances and the associated explanatory notes for these items in Category 1 - Professional Attendances.

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

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

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

a spouse, in relation to a dependant person means:

- (a) a person who is legally married to, and is not living, on a permanent basis, separately and apart from, that person; and
- (b) a de facto spouse of that person.

a child, in relation to a dependant person means:

- (a) a child under the age of 16 years who is in the custody, care and control of the person or the spouse of the person; and
- (b) a person who:
 - (i) has attained the age of 16 years who is in the custody, care and control of the person or the spouse of the person; or
 - (ii) is receiving full time education at a school, college or university; and
 - (iii) is not being paid a disability support pension under the Social Security Act 1991; and
 - (iv) is wholly or substantially dependent on the person or on the spouse of the person.

G14.1 Principles of interpretation of the MBS

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

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

G14.2 Services attracting benefits on an attendance basis

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

G14.3 Consultation and procedures rendered at the one attendance

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

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

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

G14.4 Aggregate items

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

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

G14.5 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.

G15.1 Practitioners should maintain adequate and contemporaneous records

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

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

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

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

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

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

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

Associated Notes for Items: 65060-73810

P16.6 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'.

P16.7 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.

P16.8 Hepatitis - (Item 69481)

Benefits 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".

P16.9 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.

P16.11 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 *Health Insurance Act 1973* excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, such as the Papanicolaou test. As there is now an established policy which has the support of the relevant professional bodies, routine screening in accordance with the policy will be regarded as good medical practice.

The screening policy will not be used as a basis for determining eligibility for benefits. 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.

P16.12 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.

Associated Items: 65060-73810

65060

Haemoglobin, erythrocyte sedimentation rate, blood viscosity - 1 or more tests

Fee: \$7.90 **Benefit:** 75% = \$5.95 85% = \$6.75

65066

Examination of:

- (a) a blood film by special stains to demonstrate Heinz bodies, parasites or iron; or
- (b) a blood film by enzyme cytochemistry for neutrophil alkaline phosphatase, alpha-naphthyl acetate esterase or chloroacetate esterase; or
- (c) a blood film using any other special staining methods including periodic acid Schiff and Sudan Black; or
- (d) a urinary sediment for haemosiderin

including a service described in item 65072

Fee: \$10.45 **Benefit:** 75% = \$7.85 85% = \$8.90

65070

Erythrocyte count, haematocrit, haemoglobin, calculation or measurement of red cell index or indices, platelet count, leucocyte count and manual or instrument generated differential count - not being a service where haemoglobin only is requested - one or more instrument generated set of results from a single sample; and (if performed)

- (a) a morphological assessment of a blood film;
- (b) any service in item 65060 or 65072

Fee: \$17.05 **Benefit:** 75% = \$12.80 85% = \$14.50

65072

Examination for reticulocytes including a reticulocyte count by any method - 1 or more tests

Fee: \$10.25 **Benefit:** 75% = \$7.70 85% = \$8.75

65075

Haemolysis or metabolic enzymes - assessment by:

- (a) erythrocyte autohaemolysis test; or
- (b) erythrocyte osmotic fragility test; or
- (c) sugar water test; or
- (d) G-6-P D (qualitative or quantitative) test; or
- (e) pyruvate kinase (qualitative or quantitative) test; or
- (f) acid haemolysis test; or
- (g) quantitation of muramidase in serum or urine; or
- (h) Donath Landsteiner antibody test; or
- (i) other erythrocyte metabolic enzyme tests

1 or more tests

Fee: \$52.30 **Benefit:** 75% = \$39.25 85% = \$44.50

65078

Tests for the diagnosis of thalassaemia consisting of haemoglobin electrophoresis or chromatography and at least 2 of:

- (a) examination for HbH; or
- (b) quantitation of HbA₂; or
- (c) quantitation of HbF;

including (if performed) any service described in item 65060 or 65070

Fee: \$90.80 **Benefit:** 75% = \$68.10 85% = \$77.20

65079

Tests described in item 65078 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)

Fee: \$90.80 **Benefit:** 75% = \$68.10 85% = \$77.20

65081

Tests for the investigation of haemoglobinopathy consisting of haemoglobin electrophoresis or chromatography and at least 1 of:

- (a) heat denaturation test; or
- (b) isopropanol precipitation test; or
- (c) tests for the presence of haemoglobin S; or
- (d) quantitation of any haemoglobin fraction (including S, C, D, E);

including (if performed) any service described in item 65060, 65070 or 65078

Fee: \$97.25 **Benefit:** 75% = \$72.95 85% = \$82.70

65082

Tests described in item 65081 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)

Fee: \$97.25 **Benefit:** 75% = \$72.95 85% = \$82.70

65084

Bone marrow trephine biopsy - histopathological examination of sections of bone marrow and examination of aspirated material (including clot sections where necessary), including (if performed):

any test described in item 65060, 65066 or 65070

Fee: \$166.95 **Benefit:** 75% = \$125.25 85% = \$141.95

65087

Bone marrow - examination of aspirated material (including clot sections where necessary), including (if performed):

any test described in item 65060, 65066 or 65070

Fee: \$83.65 **Benefit:** 75% = \$62.75 85% = \$71.15

65090

Blood grouping (including back-grouping if performed) - ABO and Rh (D antigen)

Fee: \$11.20 **Benefit:** 75% = \$8.40 85% = \$9.55

65093

Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including item 65090 (if performed)

Fee: \$22.15 **Benefit:** 75% = \$16.65 85% = \$18.85

65096

Blood grouping (including back-grouping if performed), and examination of serum for Rh and other blood group antibodies, including:

- (a) identification and quantitation of any antibodies detected; and
- (b) (if performed) any test described in item 65060 or 65070

Fee: \$41.30 **Benefit:** 75% = \$31.00 85% = \$35.15

65099

Compatibility tests by crossmatch - all tests performed on any one day for up to 6 units, including:

- (a) all grouping checks of the patient and donor; and
- (b) examination for antibodies, and if necessary identification of any antibodies detected; and
- (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096

(Item is subject to rule 5)

Fee: \$109.65 **Benefit:** 75% = \$82.25 85% = \$93.25

65102

Compatibility tests by crossmatch - all tests performed on any one day in excess of 6 units, including:

- (a) all grouping checks of the patient and donor; and
- (b) examination for antibodies, and if necessary identification of any antibodies detected; and
- (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105

(Item is subject to rule 5)

Fee: \$165.70 **Benefit:** 75% = \$124.30 85% = \$140.85

65105

Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day for up to 6 units, including:

- (a) all grouping checks of the patient and donor; and
- (b) examination for antibodies and, if necessary, identification of any antibodies detected; and
- (c) (if performed) any tests described in item 65060, 65070, 65090 or 65096

(Item is subject to rule 5)

Fee: \$109.65 **Benefit:** 75% = \$82.25 85% = \$93.25

65108

Compatibility testing using at least a 3 cell panel and issue of red cells for transfusion - all tests performed on any one day in excess of 6 units, including:

- (a) all grouping checks of the patient and donor; and
- (b) examination for antibodies and, if necessary, identification of any antibodies detected; and
- (c) (if performed) any tests described in item 65060, 65070, 65090, 65096, 65099 or 65105

(Item is subject to rule 5)

Fee: \$165.70 **Benefit:** 75% = \$124.30 85% = \$140.85

65109

Release of fresh frozen plasma or cryoprecipitate for the use in a patient for the correction of a coagulopathy - 1 release.

Fee: \$13.00 **Benefit:** 75% = \$9.75 85% = \$11.05

65110

Release of compatible fresh platelets for the use in a patient for platelet support as prophylaxis to minimize bleeding or during active bleeding - 1 release.

Fee: \$13.00 **Benefit:** 75% = \$9.75 85% = \$11.05

65111

Examination of serum for blood group antibodies (including identification and, if necessary, quantitation of any antibodies detected)

Fee: \$23.35 **Benefit:** 75% = \$17.55 85% = \$19.85

65114

1 or more of the following tests:

- (a) direct Coombs (antiglobulin) test;
- (b) qualitative or quantitative test for cold agglutinins or heterophil antibodies

Fee: \$9.15 **Benefit:** 75% = \$6.90 85% = \$7.80

65117

1 or more of the following tests:

- (a) Spectroscopic examination of blood for chemically altered haemoglobins;
- (b) detection of methaemalbumin (Schumm's test)

Fee: \$20.40 **Benefit:** 75% = \$15.30 85% = \$17.35

65120

Prothrombin time (including INR where appropriate), activated partial thromboplastin time, thrombin time (including test for the presence of heparin), test for factor XIII deficiency (qualitative), Echis test, Stypven test, reptilase time, fibrinogen, or 1 of fibrinogen degradation products, fibrin monomer or D-dimer - 1 test

Fee: \$13.80 **Benefit:** 75% = \$10.35 85% = \$11.75

65123

2 tests described in item 65120

Fee: \$20.50 **Benefit:** 75% = \$15.40 85% = \$17.45

65126

3 tests described in item 65120

Fee: \$28.05 **Benefit:** 75% = \$21.05 85% = \$23.85

65129

4 or more tests described in item 65120

Fee: \$35.75 **Benefit:** 75% = \$26.85 85% = \$30.40

65137

Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65175, 65176, 65177, 65178 and 65179 apply

Fee: \$25.50 **Benefit:** 75% = \$19.15 85% = \$21.70

65142

Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65175, by testing a specimen collected on a different day - 1 or more tests

Fee: \$25.50 **Benefit:** 75% = \$19.15 85% = \$21.70

65144

Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs - 1 or more tests

Fee: \$56.95 **Benefit:** 75% = \$42.75 85% = \$48.45

65147

Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test

Fee: \$38.15 **Benefit:** 75% = \$28.65 85% = \$32.45

65150

Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay - 1 test

(Item is subject to rule 6)

Fee: \$71.40 **Benefit:** 75% = \$53.55 85% = \$60.70

65153

2 tests described in item 65150

(Item is subject to rule 6)

Fee: \$142.80 **Benefit:** 75% = \$107.10 85% = \$121.40

65156

3 or more tests described in item 65150

(Item is subject to rule 6)

Fee: \$214.20 **Benefit:** 75% = \$160.65 85% = \$182.10

65157

A test described in item 65150, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6 and 18)

Fee: \$71.40 **Benefit:** 75% = \$53.55 85% = \$60.70

65158

Tests described in item 65150, other than that described in 65157, if rendered by a receiving APP - each test to a maximum of 2 tests

(Item is subject to rule 6 and 18)

Fee: \$71.40 **Benefit:** 75% = \$53.55 85% = \$60.70

65159

Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test

Fee: \$71.40 **Benefit:** 75% = \$53.55 85% = \$60.70

65162

Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test)

Fee: \$10.50 **Benefit:** 75% = \$7.90 85% = \$8.95

65165

Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162

Fee: \$34.70 **Benefit:** 75% = \$26.05 85% = \$29.50

65166

A test described in item 65165 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$34.70 **Benefit:** 75% = \$26.05 85% = \$29.50

65171

Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests

Fee: \$25.50 **Benefit:** 75% = \$19.15 85% = \$21.70

65175

Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance - where the request for the test(s) specifically identifies that the patient has a history of venous thromboembolism - quantitation by 1 or more techniques - 1 test

(Item is subject to Rule 6)

Fee: \$25.50 **Benefit:** 75% = \$19.15 85% = \$21.70

65176

2 tests described in item 65175

(Item is subject to rule 6)

Fee: \$49.00 **Benefit:** 75% = \$36.75 85% = \$41.65

65177

3 tests described in item 65175

(Item is subject to rule 6)

Fee: \$72.45 **Benefit:** 75% = \$54.35 85% = \$61.60

65178

4 tests described in item 65175

(Item is subject to rule 6)

Fee: \$95.85 **Benefit:** 75% = \$71.90 85% = \$81.50

65179

5 tests described in item 65175

(Item is subject to rule 6)

Fee: \$119.30 **Benefit:** 75% = \$89.50 85% = \$101.45

65180

A test described in item 65175, if rendered by a receiving APA, where no tests in the item have been rendered by the referring APA - 1 test

(Item is subject to rule 6 and 18)

Fee: \$25.50 **Benefit:** 75% = \$19.15 85% = \$21.70

65181

Tests described in item 65175, other than that described in 65180, if rendered by a receiving APA - each test to a maximum of 4 tests (Item is subject to rule 6 and 18)

Fee: \$23.45 **Benefit:** 75% = \$17.60 85% = \$19.95

66500

Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test

Fee: \$9.75 **Benefit:** 75% = \$7.35 85% = \$8.30

66503

2 tests described in item 66500

Fee: \$11.75 **Benefit:** 75% = \$8.85 85% = \$10.00

66506

3 tests described in item 66500

Fee: \$13.75 **Benefit:** 75% = \$10.35 85% = \$11.70

66509

4 tests described in item 66500

Fee: \$15.75 **Benefit:** 75% = \$11.85 85% = \$13.40

66512

5 or more tests described in item 66500

Fee: \$17.80 **Benefit:** 75% = \$13.35 85% = \$15.15

66517

Quantitation of bile acids in blood in pregnancy. To a maximum of 3 tests in a pregnancy.

Fee: \$19.80 **Benefit:** 75% = \$14.85 85% = \$16.85

66518

Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 1 specimen in a 24 hour period

Fee: \$20.20 **Benefit:** 75% = \$15.15 85% = \$17.20

66519

Investigation of cardiac or skeletal muscle damage by quantitative measurement of creatine kinase isoenzymes, troponin or myoglobin in blood - testing on 2 or more specimens in a 24 hour period

Fee: \$40.40 **Benefit:** 75% = \$30.30 85% = \$34.35

66536

Quantitation of HDL cholesterol

Fee: \$11.10 **Benefit:** 75% = \$8.35 85% = \$9.45

66539

Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - (Item is subject to rule 25)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66542

Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes:

- (a) administration of glucose; and
- (b) at least 2 measurements of blood glucose; and
- (c) (if performed) any test described in item 66695

Fee: \$19.10 **Benefit:** 75% = \$14.35 85% = \$16.25

66545

Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes:

- (a) administration of glucose; and
- (b) 1 or 2 measurements of blood glucose; and
- (c) (if performed) any test in item 66695

Fee: \$15.90 **Benefit:** 75% = \$11.95 85% = \$13.55

66548

Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes:

- (a) administration of glucose; and
- (b) at least 3 measurements of blood glucose; and
- (c) any test in item 66695 (if performed)

Fee: \$20.05 **Benefit:** 75% = \$15.05 85% = \$17.05

66551

Quantitation of glycosylated haemoglobin performed in the management of established diabetes - (Item is subject to rule 25)

Fee: \$16.90 **Benefit:** 75% = \$12.70 85% = \$14.40

66554

Quantitation of glycosylated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - including a service in item 66551 (if performed) (Item is subject to rule 25)

Fee: \$16.90 **Benefit:** 75% = \$12.70 85% = \$14.40

66557

Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period

Fee: \$9.75 **Benefit:** 75% = \$7.35 85% = \$8.30

66560

Microalbumin - quantitation in urine

Fee: \$20.25 **Benefit:** 75% = \$15.20 85% = \$17.25

66563

Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests

Fee: \$24.85 **Benefit:** 75% = \$18.65 85% = \$21.15

66566

Quantitation of:

(a) blood gases (including pO₂, oxygen saturation and pCO₂); and

(b) bicarbonate and pH;

including any other measurement (eg. haemoglobin, lactate, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen

Fee: \$33.95 **Benefit:** 75% = \$25.50 85% = \$28.90

66569

Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day

Fee: \$42.90 **Benefit:** 75% = \$32.20 85% = \$36.50

66572

Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day

Fee: \$51.90 **Benefit:** 75% = \$38.95 85% = \$44.15

66575

Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day

Fee: \$60.85 **Benefit:** 75% = \$45.65 85% = \$51.75

66578

Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day

Fee: \$69.80 **Benefit:** 75% = \$52.35 85% = \$59.35

66581

Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day

Fee: \$78.80 **Benefit:** 75% = \$59.10 85% = \$67.00

66584

Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test

Fee: \$9.75 **Benefit:** 75% = \$7.35 85% = \$8.30

66587

Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen

Fee: \$47.85 **Benefit:** 75% = \$35.90 85% = \$40.70

66590

Calculus, analysis of 1 or more

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66593

Ferritin - quantitation, except if requested as part of iron studies

Fee: \$18.10 **Benefit:** 75% = \$13.60 85% = \$15.40

66596

Iron studies, consisting of quantitation of:

- (a) serum iron; and
- (b) transferrin or iron binding capacity; and
- (c) ferritin

Fee: \$32.75 **Benefit:** 75% = \$24.60 85% = \$27.85

66599

Serum B12 or red cell folate and, if required, serum folate

(Item is subject to rule 21)

Fee: \$23.75 **Benefit:** 75% = \$17.85 85% = \$20.20

66602

Serum B12 and red cell folate and, if required, serum folate

(Item is subject to rule 21)

Fee: \$43.25 **Benefit:** 75% = \$32.45 85% = \$36.80

66605

Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66606

A test described in item 66605 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18 and 25)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66607

Vitamins - quantitation of vitamins A or E in blood, urine or other body fluid - 1 or more tests within a 6 month period

Fee: \$76.25 **Benefit:** 75% = \$57.20 85% = \$64.85

66608

Vitamin D or D fractions - 1 or more tests

Fee: \$42.55 **Benefit:** 75% = \$31.95 85% = \$36.20

66609

A test described in item 66608 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$42.55 **Benefit:** 75% = \$31.95 85% = \$36.20

66610

A test described in item 66607 if rendered by a receiving APP - 1 or more tests

Fee: \$76.25 **Benefit:** 75% = \$57.20 85% = \$64.85

66623

All qualitative and quantitative tests on blood, urine or other body fluid for:

- (a) a drug or drugs of abuse (including illegal drugs and legally available drugs taken other than in appropriate dosage); or
- (b) ingested or absorbed toxic chemicals;

including a service described in item 66800, 66803, 66806, 66812 or 66815 (if performed), but excluding:

- (c) the surveillance of sports people and athletes for performance improving substances; and
- (d) the monitoring of patients participating in a drug abuse treatment program

Fee: \$41.80 **Benefit:** 75% = \$31.35 85% = \$35.55

66626

Detection or quantitation or both (not including the detection of nicotine and metabolites in smoking withdrawal programs) of a drug, or drugs, of abuse or a therapeutic drug, on a sample collected from a patient participating in a drug abuse treatment program; but excluding the surveillance of sports people and athletes for performance improving substances; including all tests on blood, urine or other body fluid

(Item is subject to rule 25)

Fee: \$24.25 **Benefit:** 75% = \$18.20 85% = \$20.65

66629

Beta-2-microglobulin - quantitation in serum, urine or other body fluids - 1 or more tests

Fee: \$20.25 **Benefit:** 75% = \$15.20 85% = \$17.25

66632

Caeruloplasmin, haptoglobins, or prealbumin - quantitation in serum, urine or other body fluids - 1 or more tests

Fee: \$20.25 **Benefit:** 75% = \$15.20 85% = \$17.25

66635

Alpha-1-antitrypsin - quantitation in serum, urine or other body fluid - 1 or more tests

Fee: \$20.25 **Benefit:** 75% = \$15.20 85% = \$17.25

66638

Isoelectric focussing or similar methods for determination of alpha-1-antitrypsin phenotype in serum - 1 or more tests

Fee: \$49.40 **Benefit:** 75% = \$37.05 85% = \$42.00

66639

A test described in item 66638 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$29.40 **Benefit:** 75% = \$22.05 85% = \$25.00

66641

Electrophoresis of serum or other body fluid to demonstrate:

- (a) the isoenzymes of lactate dehydrogenase; or
- (b) the isoenzymes of alkaline phosphatase;

including the preliminary quantitation of total relevant enzyme activity - 1 or more tests

Fee: \$29.40 **Benefit:** 75% = \$22.05 85% = \$25.00

66642

A test described in item 66641 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$29.40 **Benefit:** 75% = \$22.05 85% = \$25.00

66644

C-1 esterase inhibitor - quantitation

Fee: \$20.30 **Benefit:** 75% = \$15.25 85% = \$17.30

66647

C-1 esterase inhibitor - functional assay

Fee: \$45.40 **Benefit:** 75% = \$34.05 85% = \$38.60

66650

Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), neuron specific enolase (NSE), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of hepatic tumours, gestational trophoblastic disease or germ cell tumour - quantitation - 1 test

(Item is subject to rule 6)

Fee: \$24.50 **Benefit:** 75% = \$18.40 85% = \$20.85

66651

A test described in item 66650 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$24.50 **Benefit:** 75% = \$18.40 85% = \$20.85

66652

A test described in item 66650 if rendered by a receiving APP - other than that described in 66651, if rendered by a receiving APP, 1 test

(Item is subject to rule 6 and 18)

Fee: \$20.45 **Benefit:** 75% = \$15.35 85% = \$17.40

66653

2 or more tests described in item 66650

(Item is subject to rule 6)

Fee: \$44.90 **Benefit:** 75% = \$33.70 85% = \$38.20

66655

Prostate specific antigen - quantitation - 1 of this item in a 12 month period

(Item is subject to rule 25)

Fee: \$20.30 **Benefit:** 75% = \$15.25 85% = \$17.30

66656

Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)

Fee: \$20.30 **Benefit:** 75% = \$15.25 85% = \$17.30

66659

Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the followup of a PSA result that lies at or above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period

(Item is subject to rule 25)

Fee: \$37.55 **Benefit:** 75% = \$28.20 85% = \$31.95

66660

Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/L - 4 of this item in a 12 month period.

(Item is subject to rule 25)

Fee: \$37.55 **Benefit:** 75% = \$28.20 85% = \$31.95

66662

Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests

Fee: \$80.50 **Benefit:** 75% = \$60.40 85% = \$68.45

66663

A test described in item 66662 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$80.50 **Benefit:** 75% = \$60.40 85% = \$68.45

66665

Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66666

A test described in item 66665 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66667

Quantitation of serum zinc in a patient receiving intravenous alimentation - each test

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66671

Quantitation of serum aluminium in a patient in a renal dialysis program - each test

Fee: \$37.15 **Benefit:** 75% = \$27.90 85% = \$31.60

66674

Quantitation of:

- (a) faecal fat; or
- (b) breath hydrogen in response to loading with disaccharides;

1 or more tests within a 28 day period

Fee: \$40.20 **Benefit:** 75% = \$30.15 85% = \$34.20

66677

Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old

Fee: \$11.25 **Benefit:** 75% = \$8.45 85% = \$9.60

66680

Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests

Fee: \$74.95 **Benefit:** 75% = \$56.25 85% = \$63.75

66683

Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests

Fee: \$74.95 **Benefit:** 75% = \$56.25 85% = \$63.75

66686

Performance of 1 or more of the following procedures:

- (a) growth hormone suppression by glucose loading;
- (b) growth hormone stimulation by exercise;
- (c) dexamethasone suppression test;
- (d) sweat collection by iontophoresis for chloride analysis;
- (e) pharmacological stimulation of growth hormone

Fee: \$51.00 **Benefit:** 75% = \$38.25 85% = \$43.35

66695

Quantitation in blood or urine of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, - 1 test

(Item is subject to rule 6)

Fee: \$30.70 **Benefit:** 75% = \$23.05 85% = \$26.10

66696

A test described in item 66695, if rendered by a receiving APP - where no tests in the item have been rendered by the referring APP

(Item is subject to rule 6 and 18)

Fee: \$30.70 **Benefit:** 75% = \$23.05 85% = \$26.10

66697

Tests described in item 66695, other than that described in 66696, if rendered by a receiving APP - each test to a maximum of 4 tests

(Item is subject to rule 6 and 18)

Fee: \$13.30 **Benefit:** 75% = \$10.00 85% = \$11.35

66698

2 tests described in item 66695

(Item is subject to rule 6)

Fee: \$44.00 **Benefit:** 75% = \$33.00 85% = \$37.40

66701

3 tests described in item 66695

(Item is subject to rule 6)

Fee: \$57.30 **Benefit:** 75% = \$43.00 85% = \$48.75

66704

4 tests described in item 66695

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA)

(Item is subject to rule 6)

Fee: \$70.60 **Benefit:** 75% = \$52.95 85% = \$60.05

66707

5 or more tests described in item 66695

(Item is subject to rule 6)

Fee: \$83.90 **Benefit:** 75% = \$62.95 85% = \$71.35

66711

Quantitation in saliva of cortisol in:

- (a) the investigation of Cushing's syndrome; or
- (b) the management of children with congenital adrenal hyperplasia

(Item is subject to rule 6)

Fee: \$30.35 **Benefit:** 75% = \$22.80 85% = \$25.80

66712

Two tests described in item 66711

(Item is subject to rule 6)

Fee: \$43.35 **Benefit:** 75% = \$32.55 85% = \$36.85

66714

A test described in item 66711, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP

(Item is subject to rule 6 and 18)

Fee: \$30.35 **Benefit:** 75% = \$22.80 85% = \$25.80

66715

Tests described in item 66711, other than that described in 66714, if rendered by a receiving APP, each test to a maximum of 1 test

(Item is subject to rule 6 and 18)

Fee: \$12.95 **Benefit:** 75% = \$9.75 85% = \$11.05

66716

TSH quantitation

Fee: \$25.20 **Benefit:** 75% = \$18.90 85% = \$21.45

66719

Thyroid function tests (comprising the service described in item 66716 and 1 or more of the following tests - free thyroxine, free T3, for a patient, if at least 1 of the following conditions is satisfied:

- (a) the patient has an abnormal level of TSH;
- (b) the tests are performed:
 - (i) for the purpose of monitoring thyroid disease in the patient; or
 - (ii) to investigate the sick euthyroid syndrome if the patient is an admitted patient; or
 - (iii) to investigate dementia or psychiatric illness of the patient; or
 - (iv) to investigate amenorrhoea or infertility of the patient;
- (c) the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction;
- (d) the patient is on drugs that interfere with thyroid hormone metabolism or function

(Item is subject to rule 9)

Fee: \$35.05 **Benefit:** 75% = \$26.30 85% = \$29.80

66722

TSH quantitation described in item 66716 and 1 test described in item 66695

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA)

(Item is subject to rule 6)

Fee: \$38.15 **Benefit:** 75% = \$28.65 85% = \$32.45

66723

Tests described in item 66722, that is, TSH quantitation and 1 test described in 66695, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$38.15 **Benefit:** 75% = \$28.65 85% = \$32.45

66724

Tests described in item 66722, if rendered by a receiving APP, other than that described in 66723. It is to include a quantitation of TSH - each test to a maximum of 4 tests described in item 66695

(Item is subject to rule 6 and 18)

Fee: \$13.25 **Benefit:** 75% = \$9.95 85% = \$11.30

66725

TSH quantitation described in item 66716 and 2 tests described in item 66695

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA)

(Item is subject to rule 6)

Fee: \$51.40 **Benefit:** 75% = \$38.55 85% = \$43.70

66728

TSH quantitation described in item 66716 and 3 tests described in item 66695

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA)

(Item is subject to rule 6)

Fee: \$64.65 **Benefit:** 75% = \$48.50 85% = \$55.00

66731

TSH quantitation described in item 66716 and 4 tests described in item 66695

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA)

(Item is subject to rule 6)

Fee: \$77.90 **Benefit:** 75% = \$58.45 85% = \$66.25

66734

TSH quantitation described in item 66716 and 5 tests described in item 66695

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form)

(Item is subject to rule 6)

Fee: \$91.15 **Benefit:** 75% = \$68.40 85% = \$77.50

66743

Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751

Fee: \$20.25 **Benefit:** 75% = \$15.20 85% = \$17.25

66749

Amniotic fluid, spectrophotometric examination of, and quantitation of:

- (a) lecithin/sphingomyelin ratio; or
- (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or
- (c) bilirubin, including correction for haemoglobin

1 or more tests

Fee: \$33.15 **Benefit:** 75% = \$24.90 85% = \$28.20

66750

Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE₃), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - (Item is subject to rule 25)

Fee: \$40.00 **Benefit:** 75% = \$30.00 85% = \$34.00

66751

Quantitation, in pregnancy, of any three or more tests described in 66750

(Item is subject to rule 25)

Fee: \$55.60 **Benefit:** 75% = \$41.70 85% = \$47.30

66752

Quantitation of acetoacetate, beta-hydroxybutyrate, citrate, oxalate, total free fatty acids, cysteine, homocysteine, cystine, lactate, pyruvate or other amino acids and hydroxyproline (except if performed as part of item 66773 or 66776) - 1 test

Fee: \$24.85 **Benefit:** 75% = \$18.65 85% = \$21.15

66755

2 or more tests described in item 66752

Fee: \$39.10 **Benefit:** 75% = \$29.35 85% = \$33.25

66756

Quantitation of 10 or more amino acids for the diagnosis of inborn errors of metabolism - up to 4 tests in a 12 month period on specimens of plasma, CSF and urine.

Fee: \$98.95 **Benefit:** 75% = \$74.25 85% = \$84.15

66757

Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type.

Fee: \$98.95 **Benefit:** 75% = \$74.25 85% = \$84.15

66758

Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests

Fee: \$24.85 **Benefit:** 75% = \$18.65 85% = \$21.15

66761

Test for reducing substances in faeces by any method (except reagent strip or dipstick)

Fee: \$13.25 **Benefit:** 75% = \$9.95 85% = \$11.30

66764

Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces except by reagent strip or dip stick methods) with a maximum of 3 examinations on specimens collected on separate days in a 28 day period

Fee: \$8.95 **Benefit:** 75% = \$6.75 85% = \$7.65

66767

2 examinations described in item 66764 performed on separately collected and identified specimens

Fee: \$17.95 **Benefit:** 75% = \$13.50 85% = \$15.30

66770

3 examinations described in item 66764 performed on separately collected and identified specimens

Fee: \$26.90 **Benefit:** 75% = \$20.20 85% = \$22.90

66773

Quantitation of products of collagen breakdown or formation for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752 - 1 or more tests

(Low bone densitometry is defined in the explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule)

Fee: \$24.80 **Benefit:** 75% = \$18.60 85% = \$21.10

66776

Quantitation of products of collagen breakdown or formation for the monitoring of patients with metabolic bone disease or Paget's disease of bone, and if performed, a service described in item 66752 - 1 or more tests

Fee: \$24.80 **Benefit:** 75% = \$18.60 85% = \$21.10

66779

Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (5HIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotonin quantitation - 1 or more tests

Fee: \$40.20 **Benefit:** 75% = \$30.15 85% = \$34.20

66780

A test described in item 66779 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$40.20 **Benefit:** 75% = \$30.15 85% = \$34.20

66782

Porphyryns or porphyryns precursors - detection in plasma, red cells, urine or faeces - 1 or more tests

Fee: \$13.25 **Benefit:** 75% = \$9.95 85% = \$11.30

66783

A test described in item 66782 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$13.25 **Benefit:** 75% = \$9.95 85% = \$11.30

66785

Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 1 test

(Item is subject to rule 6)

Fee: \$40.20 **Benefit:** 75% = \$30.15 85% = \$34.20

66788

Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests

(Item is subject to rule 6)

Fee: \$66.30 **Benefit:** 75% = \$49.75 85% = \$56.40

66789

A test described in item 66785 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$40.20 **Benefit:** 75% = \$30.15 85% = \$34.20

66790

A test described in item 66785 other than that described in 66789, if rendered by a receiving APP - to a maximum of 1 test

(Item is subject to rule 6 and 18)

Fee: \$26.05 **Benefit:** 75% = \$19.55 85% = \$22.15

66791

Porphyrin biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests

Fee: \$74.95 **Benefit:** 75% = \$56.25 85% = \$63.75

66792

A test described in item 66791 if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$74.95 **Benefit:** 75% = \$56.25 85% = \$63.75

66800

Quantitation in blood, urine or other body fluid by any method (except reagent tablet or reagent strip) of any of the following being used therapeutically by the patient from whom the specimen was taken: amikacin, carbamazepine, digoxin, disopyramide, ethanol, ethosuximide, gentamicin, lithium, lignocaine, netilmicin, paracetamol, phenobarbitone, primidone, phenytoin, procainamide, quinidine, salicylate, theophylline, tobramycin, valproate or vancomycin - 1 test

(Item to be subject to rule 6)

(See para [P16.6](#) of explanatory notes to this Category)

Fee: \$18.25 **Benefit:** 75% = \$13.70 85% = \$15.55

66803

2 tests described in item 66800

(Item is subject to rule 6)

Fee: \$30.70 **Benefit:** 75% = \$23.05 85% = \$26.10

66804

A test described in item 66800 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$18.25 **Benefit:** 75% = \$13.70 85% = \$15.55

66805

A test described in item 66800 other than that described in 66804, if rendered by a receiving APP - each test to a maximum of 2 tests

(Item is subject to rule 6 and 18)

Fee: \$12.45 **Benefit:** 75% = \$9.35 85% = \$10.60

66806

3 tests described in item 66800

(Item is subject to rule 6)

Fee: \$42.15 **Benefit:** 75% = \$31.65 85% = \$35.85

66812

Quantitation, not elsewhere described in this Table by any method or methods, in blood, urine or other body fluid, of a drug being used therapeutically by the patient from whom the specimen was taken - 1 test

(This fee applies where 1 laboratory performs the only test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)

(See para [P16.6](#) of explanatory notes to this Category)

Fee: \$35.05 **Benefit:** 75% = \$26.30 85% = \$29.80

66815

2 tests described in item 66812

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)

Fee: \$59.95 **Benefit:** 75% = \$45.00 85% = \$51.00

66816

A test described in item 66812 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$35.05 **Benefit:** 75% = \$26.30 85% = \$29.80

66817

A test described in item 66812, other than that described in 66816, if rendered by a receiving APP - to a maximum of 1 test

(Item is subject to rule 6 and 18)

Fee: \$24.90 **Benefit:** 75% = \$18.70 85% = \$21.20

66819

Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid - 1 test.

(Item is subject to rule 6, 22 and 25)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66820

A test described in item 66819 if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6, 18, 22 and 25)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66821

A test described in item 66819 other than that described in 66820 if rendered by a receiving APP to a maximum of 1 test

(Item is subject to rule 6, 18, 22 and 25)

Fee: \$21.95 **Benefit:** 75% = \$16.50 85% = \$18.70

66822

Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid - 2 or more tests.

(Item is subject to rule 6, 22 and 25)

Fee: \$52.80 **Benefit:** 75% = \$39.60 85% = \$44.90

66825

Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test. To a maximum of 3 of this item in a 6 month period

(Item is subject to rule 6, 22 and 25)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66826

A test described in item 66825 if rendered by a receiving APP where no tests have been rendered by the referring APP - 1 test

(Item is subject to rules 6, 18, 22 and 25)

Fee: \$30.80 **Benefit:** 75% = \$23.10 85% = \$26.20

66827

A test described in item 66825, other than that described in 66826, if rendered by a receiving APP to a maximum of 1 test

(Item is subject to rules 6, 18, 22 and 25)

Fee: \$21.95 **Benefit:** 75% = \$16.50 85% = \$18.70

66828

Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests. To a maximum of 3 of this item in a 6 month period

(Item is subject to rule 6, 22 and 25)

Fee: \$52.80 **Benefit:** 75% = \$39.60 85% = \$44.90

66830

Quantitation of BNP or NT-proBNP for the diagnosis of heart failure in patients presenting with dyspnoea to a hospital Emergency Department

(Item is subject to rule 25)

Fee: \$58.90 **Benefit:** 75% = \$44.20 85% = \$50.10

66831

Quantitation of copper or iron in liver tissue biopsy

Fee: \$31.15 **Benefit:** 75% = \$23.40 85% = \$26.50

66832

A test described in item 66831 if rendered by a receiving APP

(Item is subject to rule 18A and 22)

Fee: \$31.15 **Benefit:** 75% = \$23.40 85% = \$26.50

66900

CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, including the measurement of exhaled $^{13}\text{CO}_2$ or $^{14}\text{CO}_2$ (except if item 12533 applies) for either:-

- (a) the confirmation of *Helicobacter pylori* colonisation OR
- (b) the monitoring of the success of eradication of *Helicobacter pylori*.

Fee: \$78.15 **Benefit:** 75% = \$58.65 85% = \$66.45

69300

Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including:

- (a) differential cell count (if performed); or
- (b) examination for dermatophytes; or
- (c) dark ground illumination; or
- (d) stained preparation or preparations using any relevant stain or stains;

1 or more tests

Fee: \$12.60 **Benefit:** 75% = \$9.45 85% = \$10.75

69303

Culture and (if performed) microscopy to detect pathogenic micro-organisms from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed):

- (a) pathogen identification and antibiotic susceptibility testing; or
- (b) a service described in item 69300;

specimens from 1 or more sites

Fee: \$22.15 **Benefit:** 75% = \$16.65 85% = \$18.85

69306

Microscopy and culture to detect pathogenic micro-organisms from skin or other superficial sites, including (if performed):

- (a) pathogen identification and antibiotic susceptibility testing; or
- (b) a service described in items 69300, 69303, 69312, 69318;

1 or more tests on 1 or more specimens

Fee: \$34.00 **Benefit:** 75% = \$25.50 85% = \$28.90

69309

Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding

swab specimens) and including (if performed):

- (a) the detection of antigens not elsewhere specified in this Table; or
- (b) a service described in items 69300, 69303, 69306, 69312, 69318;

1 or more tests on 1 or more specimens

Fee: \$48.45 **Benefit:** 75% = \$36.35 85% = \$41.20

69312

Microscopy and culture to detect pathogenic micro-organisms from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed):

- (a) pathogen identification and antibiotic susceptibility testing; or
- (b) a service described in items 69300, 69303, 69306 and 69318;

1 or more tests on 1 or more specimens

Fee: \$34.00 **Benefit:** 75% = \$25.50 85% = \$28.90

69316

Detection of Chlamydia trachomatis by any method - 1 test (Item is subject to rule 26)

Fee: \$28.85 **Benefit:** 75% = \$21.65 85% = \$24.55

69317

1 test described in item 69494 and a test described in 69316. (Item is subject to rule 26)

Fee: \$36.10 **Benefit:** 75% = \$27.10 85% = \$30.70

69318

Microscopy and culture to detect pathogenic micro-organisms from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed):

- (a) pathogen identification and antibiotic susceptibility testing; or
- (b) a service described in items 69300, 69303, 69306 and 69312;

1 or more tests on 1 or more specimens

Fee: \$34.00 **Benefit:** 75% = \$25.50 85% = \$28.90

69319

2 tests described in item 69494 and a test described in 69316. (Item is subject to rule 26)

Fee: \$43.25 **Benefit:** 75% = \$32.45 85% = \$36.80

69321

Microscopy and culture of post-operative wounds, aspirates of body cavities, synovial fluid, CSF or operative or biopsy specimens, for the presence of pathogenic micro-organisms involving aerobic and anaerobic cultures and the use of different culture media, and including (if performed):

- (a) pathogen identification and antibiotic susceptibility testing; or
- (b) a service described in item 69300, 69303, 69306, 69312 or 69318;

specimens from 1 or more sites

Fee: \$48.45 **Benefit:** 75% = \$36.35 85% = \$41.20

69324

Microscopy (with appropriate stains) and culture for mycobacteria - 1 specimen of sputum, urine, or other body fluid or 1 operative or biopsy specimen, including (if performed):

- (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or
- (b) pathogen identification and antibiotic susceptibility testing;

including a service mentioned in item 69300

Fee: \$43.30 **Benefit:** 75% = \$32.50 85% = \$36.85

69325

A test described in item 69324 if rendered by a receiving APP

(Item is subject to rule 18)

Fee: \$43.30 **Benefit:** 75% = \$32.50 85% = \$36.85

69327

Microscopy (with appropriate stains) and culture for mycobacteria - 2 specimens of sputum, urine, or other body fluid or 2 operative or biopsy specimens, including (if performed):

- (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or
- (b) pathogen identification and antibiotic susceptibility testing;

including a service mentioned in item 69300

Fee: \$85.55 **Benefit:** 75% = \$64.20 85% = \$72.75

69328

A test described in item 69327 if rendered by a receiving APP

(Item is subject to rule 18)

Fee: \$85.55 **Benefit:** 75% = \$64.20 85% = \$72.75

69330

Microscopy (with appropriate stains) and culture for mycobacteria - 3 specimens of sputum, urine, or other body fluid or 3 operative or biopsy specimens, including (if performed):

- (a) microscopy and culture of other bacterial pathogens isolated as a result of this procedure; or
- (b) pathogen identification and antibiotic susceptibility testing;

including a service mentioned in item 69300

Fee: \$128.85 **Benefit:** 75% = \$96.65 85% = \$109.55

69331

A test described in item 69330 if rendered by a receiving APP

(Item is subject to rule 18)

Fee: \$128.85 **Benefit:** 75% = \$96.65 85% = \$109.55

69333

Urine examination (including serial examination) by any means other than simple culture by dip slide, including:

- (a) cell count; and
- (b) culture; and
- (c) colony count; and
- (d) (if performed) stained preparations; and
- (e) (if performed) identification of cultured pathogens; and
- (f) (if performed) antibiotic susceptibility testing; and
- (g) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts

Fee: \$20.70 **Benefit:** 75% = \$15.55 85% = \$17.60

69336

Microscopy of faeces for ova, cysts and parasites that must include a concentration technique, and the use of fixed stains or antigen detection for cryptosporidia and giardia - including (if performed) a service mentioned in item 69300 - 1 of this item in any 7 day period

Fee: \$33.65 **Benefit:** 75% = \$25.25 85% = \$28.65

69339

Microscopy of faeces for ova, cysts and parasites using concentration techniques examined subsequent to item 69336 on a separately collected and identified specimen collected within 7 days of the examination described in 69336 - 1 examination in any 7 day period

Fee: \$19.25 **Benefit:** 75% = \$14.45 85% = \$16.40

69345

Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed):

- (a) pathogen identification and antibiotic susceptibility testing; and
- (b) the detection of clostridial toxins; and
- (c) a service described in item 69300;

- 1 examination in any 7 day period

Fee: \$53.25 **Benefit:** 75% = \$39.95 85% = \$45.30

69354

Blood culture for pathogenic micro-organisms (other than viruses), including sub-cultures and (if performed):

- (a) identification of any cultured pathogen; and
- (b) necessary antibiotic susceptibility testing;

to a maximum of 3 sets of cultures - 1 set of cultures

Fee: \$30.95 **Benefit:** 75% = \$23.25 85% = \$26.35

69357

2 sets of cultures described in item 69354

Fee: \$61.85 **Benefit:** 75% = \$46.40 85% = \$52.60

69360

3 sets of cultures described in item 69354

Fee: \$92.80 **Benefit:** 75% = \$69.60 85% = \$78.90

69363

Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in items 69345, 69369, 69370, 69373 or 69375 has been performed) - 1 or more tests

Fee: \$28.85 **Benefit:** 75% = \$21.65 85% = \$24.55

69378

Quantitation of HIV viral RNA load in plasma or serum in the monitoring of a HIV sero-positive patient not on antiretroviral therapy - 1 or more tests

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69379

A test described in item 69378 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69380

Genotypic testing for HIV antiretroviral resistance in a patient with confirmed HIV infection if the patient's viral load is greater than 1,000 copies per ml at any of the following times:

- (a) at presentation; or
- (b) before antiretroviral therapy; or
- (c) when treatment with combination antiretroviral agents fails;

maximum of 2 tests in a 12 month period

Fee: \$775.50 **Benefit:** 75% = \$581.65 85% = \$704.30

69381

Quantitation of HIV viral RNA load in plasma or serum in the monitoring of antiretroviral therapy in a HIV sero-positive patient - 1 or more tests on 1 or more specimens

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69382

Quantitation of HIV viral RNA load in cerebrospinal fluid in a HIV sero-positive patient - 1 or more tests on 1 or more specimens

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69383

A test described in item 69381 if rendered by a receiving APP - 1 or more tests on 1 or more specimens

(Item is subject to rule 18)

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69384

Quantitation of 1 antibody to microbial antigens not elsewhere described in the Schedule - 1 test

(This fee applies where a laboratory performs the only antibody test specified on the request form or performs 1 test and refers the rest to the laboratory of a separate APA)

(Item is subject to rule 6)

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$15.75 **Benefit:** 75% = \$11.85 85% = \$13.40

69387

2 tests described in item 69384

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 estimations specified on the request form or performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA)

(Item is subject to rule 6)

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$29.20 **Benefit:** 75% = \$21.90 85% = \$24.85

69390

3 tests described in item 69384

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA)

(Item is subject to rule 6)

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$42.65 **Benefit:** 75% = \$32.00 85% = \$36.30

69393

4 tests described in item 69384

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA)

(Item is subject to rule 6)

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$56.10 **Benefit:** 75% = \$42.10 85% = \$47.70

69396

5 or more tests described in item 69384

(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA)

(Item is subject to rule 6)

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$69.55 **Benefit:** 75% = \$52.20 85% = \$59.15

69400

A test described in item 69384, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rules 6 and 18)

Fee: \$15.75 **Benefit:** 75% = \$11.85 85% = \$13.40

69401

A test described in item 69384, other than that described in 69400, if rendered by a receiving APP - each test to a maximum of 4 tests

(Item is subject to rule 6, 18 and 18A)

Fee: \$13.45 **Benefit:** 75% = \$10.10 85% = \$11.45

69405

Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:

(a) the determination of 1 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and

(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$15.75 **Benefit:** 75% = \$11.85 85% = \$13.40

69408

Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:

(a) the determination of 2 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and

(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$29.20 **Benefit:** 75% = \$21.90 85% = \$24.85

69411

Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:

(a) the determination of 3 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and

(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$42.65 **Benefit:** 75% = \$32.00 85% = \$36.30

69413

Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:

- (a) the determination of 4 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and
- (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$56.10 **Benefit:** 75% = \$42.10 85% = \$47.70

69415

Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:

- (a) the determination of all 5 of the following - rubella immune status, specific syphilis serology, carriage of Hepatitis B, Hepatitis C antibody, HIV antibody and
- (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478 and 69481

(See para [P16.7](#) of explanatory notes to this Category)

Fee: \$69.55 **Benefit:** 75% = \$52.20 85% = \$59.15

69418

A test for high risk human papillomaviruses (HPV) in a patient who:

- has received excisional or ablative treatment for high grade squamous intraepithelial lesions (HSIL) of the cervix within the last two years; or
- who within the last two years has had a positive HPV test after excisional or ablative treatment for HSIL of the cervix; or
- is already undergoing annual cytological review for the follow-up of a previously treated HSIL.
- to a maximum of 2 of this item in a 24 month period

(Item is subject to rule 25)

Fee: \$64.00 **Benefit:** 75% = \$48.00 85% = \$54.40

69419

A test described in item 69418 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)

Fee: \$64.00 **Benefit:** 75% = \$48.00 85% = \$54.40

69445

Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69499) - 1 test. To a maximum of 4 of this item in a 12 month period

(Item is subject to rule 25)

Fee: \$92.80 **Benefit:** 75% = \$69.60 85% = \$78.90

69451

A test described in item 69445 if rendered by a receiving APP - 1 test.

(Item is subject to rule 18 and 25)

Fee: \$92.80 **Benefit:** 75% = \$69.60 85% = \$78.90

69471

Test of cell-mediated immunity in blood for the detection of latent tuberculosis in an immunosuppressed or immunocompromised patient - 1 test

Fee: \$35.15 **Benefit:** 75% = \$26.40 85% = \$29.90

69472

Detection of antibodies to Epstein Barr Virus using specific serology - 1 test

Fee: \$15.75 **Benefit:** 75% = \$11.85 85% = \$13.40

69474

Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests

Fee: \$28.85 **Benefit:** 75% = \$21.65 85% = \$24.55

69475

One test for hepatitis antigen or antibodies to determine immune status or viral carriage following exposure or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D

(Item subject to rule 11)

Fee: \$15.75 **Benefit:** 75% = \$11.85 85% = \$13.40

69478

2 tests described in 69475

(Item subject to rule 11)

Fee: \$29.45 **Benefit:** 75% = \$22.10 85% = \$25.05

69481

Investigation of infectious causes of acute or chronic hepatitis - 3 tests for hepatitis antibodies or antigens,

(Item subject to rule 11)

(See para [P16.8](#) of explanatory notes to this Category)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

69482

Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and have chronic hepatitis B, but are not receiving antiviral therapy - 1 test

(Item is subject to rule 25)

Fee: \$153.10 **Benefit:** 75% = \$114.85 85% = \$130.15

69483

Quantitation of Hepatitis B viral DNA in patients who are Hepatitis B surface antigen positive and who have chronic hepatitis B and are receiving antiviral therapy - 1 test

(Item is subject to rule 25)

Fee: \$153.10 **Benefit:** 75% = \$114.85 85% = \$130.15

69484

Supplementary testing for Hepatitis B surface antigen or Hepatitis C antibody using a different assay on the specimen which yielded a reactive result on initial testing

(Item is subject to rule 18)

Fee: \$17.20 **Benefit:** 75% = \$12.90 85% = \$14.65

69488

Quantitation of HCV RNA load in plasma or serum in the pretreatment evaluation or the assessment of efficacy of antiviral therapy of a patient with chronic HCV hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis (including a service in item 69499 or 69445)

(Item is subject to rule 18 and 25)

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69489

A test described in item 69488 if rendered by a receiving APP

(Item is subject to rule 18 and 25)

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

69491

Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if:

- (a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis; and
- (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient;

To a maximum of 1 of this item in a 12 month period

Fee: \$206.20 **Benefit:** 75% = \$154.65 85% = \$175.30

69492

A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)

Fee: \$206.20 **Benefit:** 75% = \$154.65 85% = \$175.30

69494

Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified)

1 test

(Item is subject to rule 6 and 26)

Fee: \$28.85 **Benefit:** 75% = \$21.65 85% = \$24.55

69495

2 tests described in 69494

(Item is subject to rule 6 and 26)

Fee: \$36.10 **Benefit:** 75% = \$27.10 85% = \$30.70

69496

3 or more tests described in 69494

(Item is subject to rule 6 and 26)

Fee: \$43.35 **Benefit:** 75% = \$32.55 85% = \$36.85

69497

A test described in item 69494, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test (Item is subject to rule 6, 18 and 26)

Fee: \$28.85 **Benefit:** 75% = \$21.65 85% = \$24.55

69498

A test described in item 69494, other than that described in 69497, if rendered by a receiving APP - each test to a maximum of 2 tests (Item is subject to rule 6, 18 and 26)

Fee: \$7.25 **Benefit:** 75% = \$5.45 85% = \$6.20

69499

Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied:

- (a) the patient is Hepatitis C seropositive;
- (b) the patient's serological status is uncertain after testing;
- (c) the test is performed for the purpose of:
 - (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or
 - (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient;

To a maximum of 1 of this item in a 12 month period

(Item is subject to rule 19 and 25)

Fee: \$92.80 **Benefit:** 75% = \$69.60 85% = \$78.90

69500

A test described in item 69499 if rendered by a receiving APP - 1 test (Item is subject to rule 18,19 and 25)

Fee: \$92.80 **Benefit:** 75% = \$69.60 85% = \$78.90

71057

Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate:

- (a) protein classes; or
- (b) presence and amount of paraprotein;

including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type

Fee: \$33.10 **Benefit:** 75% = \$24.85 85% = \$28.15

71058

Examination as described in item 71057 of 2 or more specimen types

Fee: \$50.85 **Benefit:** 75% = \$38.15 85% = \$43.25

71059

Immunofixation or immunoelectrophoresis or isoelectric focusing of:

- (a) urine for detection of Bence Jones proteins; or
- (b) serum, plasma or other body fluid;

and characterisation of a paraprotein or cryoglobulin -

examination of 1 specimen type (eg. serum, urine or CSF)

Fee: \$35.90 **Benefit:** 75% = \$26.95 85% = \$30.55

71060

Examination as described in item 71059 of 2 or more specimen types

Fee: \$44.35 **Benefit:** 75% = \$33.30 85% = \$37.70

71062

Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes - 1 or more tests

Fee: \$44.35 **Benefit:** 75% = \$33.30 85% = \$37.70

71064

Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests

Fee: \$20.90 **Benefit:** 75% = \$15.70 85% = \$17.80

71066

Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test

Fee: \$14.65 **Benefit:** 75% = \$11.00 85% = \$12.50

71068

Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test

Fee: \$14.65 **Benefit:** 75% = \$11.00 85% = \$12.50

71069

2 tests described in items 71066, 71068, 71072 or 71074

Fee: \$22.90 **Benefit:** 75% = \$17.20 85% = \$19.50

71071

3 or more tests described in items 71066, 71068, 71072 or 71074

Fee: \$31.15 **Benefit:** 75% = \$23.40 85% = \$26.50

71072

Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test

Fee: \$14.65 **Benefit:** 75% = \$11.00 85% = \$12.50

71073

Quantitation of all 4 immunoglobulin G subclasses

Fee: \$106.85 **Benefit:** 75% = \$80.15 85% = \$90.85

71074

Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test

Fee: \$14.65 **Benefit:** 75% = \$11.00 85% = \$12.50

71075

Quantitation of immunoglobulin E (total), 1 test.

(Item is subject to rule 25)

Fee: \$23.15 **Benefit:** 75% = \$17.40 85% = \$19.70

71076

A test described in item 71073 if rendered by a receiving APP - 1 test

(Item is subject to rule 18)

Fee: \$106.85 **Benefit:** 75% = \$80.15 85% = \$90.85

71077

Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, 1 test.

(Item is subject to rule 25)

Fee: \$27.25 **Benefit:** 75% = \$20.45 85% = \$23.20

71079

Detection of specific immunoglobulin E antibodies to single or multiple potential allergens, 1 test

(Item is subject to rule 25)

Fee: \$27.00 **Benefit:** 75% = \$20.25 85% = \$22.95

71081

Quantitation of total haemolytic complement

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

71083

Quantitation of complement components C3 and C4 or properdin factor B - 1 test

Fee: \$20.30 **Benefit:** 75% = \$15.25 85% = \$17.30

71085

2 tests described in item 71083

Fee: \$29.15 **Benefit:** 75% = \$21.90 85% = \$24.80

71087

3 or more tests described in item 71083

Fee: \$37.95 **Benefit:** 75% = \$28.50 85% = \$32.30

71089

Quantitation of complement components or breakdown products of complement proteins not elsewhere described in an item in this Schedule - 1 test

(Item is subject to rule 6)

Fee: \$29.35 **Benefit:** 75% = \$22.05 85% = \$24.95

71090

A test described in item 71089, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$29.35 **Benefit:** 75% = \$22.05 85% = \$24.95

71091

2 tests described in item 71089

(Item is subject to rule 6)

Fee: \$53.20 **Benefit:** 75% = \$39.90 85% = \$45.25

71092

Tests described in item 71089, other than that described in 71090, if rendered by a receiving APP - each test to a maximum of 2 tests

(Item is subject to rule 6 and 18)

Fee: \$23.85 **Benefit:** 75% = \$17.90 85% = \$20.30

71093

3 or more tests described in item 71089

(Item is subject to rule 6)

Fee: \$76.95 **Benefit:** 75% = \$57.75 85% = \$65.45

71095

Quantitation of serum or plasma eosinophil cationic protein, or both, to a maximum of 3 assays in 1 year, for monitoring the response to therapy in corticosteroid treated asthma, in a child aged less than 12 years

(See para [P16.9](#) of explanatory notes to this Category)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

71096

A test described in item 71095 if rendered by a receiving APP.

(Item is subject to rule 18)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

71097

Antinuclear antibodies - detection in serum or other body fluids, including quantitation if required

Fee: \$24.60 **Benefit:** 75% = \$18.45 85% = \$20.95

71099

Double-stranded DNA antibodies - quantitation by 1 or more methods other than the Crithidia method

Fee: \$26.70 **Benefit:** 75% = \$20.05 85% = \$22.70

71101

Antibodies to 1 or more extractable nuclear antigens - detection in serum or other body fluids

Fee: \$17.50 **Benefit:** 75% = \$13.15 85% = \$14.90

71103

Characterisation of an antibody detected in a service described in item 71101 (including that service)

Fee: \$52.40 **Benefit:** 75% = \$39.30 85% = \$44.55

71106

Rheumatoid factor - detection by any technique in serum or other body fluids, including quantitation if required

Fee: \$11.40 **Benefit:** 75% = \$8.55 85% = \$9.70

71119

Antibodies to tissue antigens not elsewhere specified in this Table - detection, including quantitation if required, of 1 antibody

Fee: \$17.45 **Benefit:** 75% = \$13.10 85% = \$14.85

71121

Detection of 2 antibodies specified in item 71119

Fee: \$20.95 **Benefit:** 75% = \$15.75 85% = \$17.85

71123

Detection of 3 antibodies specified in item 71119

Fee: \$24.40 **Benefit:** 75% = \$18.30 85% = \$20.75

71125

Detection of 4 or more antibodies specified in item 71119

Fee: \$27.85 **Benefit:** 75% = \$20.90 85% = \$23.70

71127

Functional tests for lymphocytes - quantitation other than by microscopy of:

- (a) proliferation induced by 1 or more mitogens; or
- (b) proliferation induced by 1 or more antigens; or
- (c) estimation of 1 or more mixed lymphocyte reactions;

including a test described in item 65066 or 65070 (if performed), 1 of this item to a maximum of 2 in a 12 month period

Fee: \$177.55 **Benefit:** 75% = \$133.20 85% = \$150.95

71129

2 tests described in item 71127

Fee: \$219.30 **Benefit:** 75% = \$164.50 85% = \$186.45

71131

3 or more tests described in item 71127

Fee: \$261.10 **Benefit:** 75% = \$195.85 85% = \$221.95

71133

Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test

Fee: \$10.45 **Benefit:** 75% = \$7.85 85% = \$8.90

71134

Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)

Fee: \$104.75 **Benefit:** 75% = \$78.60 85% = \$89.05

71135

Quantitation of neutrophil function, comprising at least 2 of the following:

- (a) chemotaxis;
- (b) phagocytosis;
- (c) oxidative metabolism;
- (d) bactericidal activity;

including any test described in items 65066, 65070, 71133 or 71134 (if performed), 1 of this item to a maximum of 2 in a 12 month period

Fee: \$209.35 **Benefit:** 75% = \$157.05 85% = \$177.95

71137

Quantitation of cell-mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, 1 of this item to a maximum of 2 in a 12 month period

Fee: \$30.45 **Benefit:** 75% = \$22.85 85% = \$25.90

71139

Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations, including a total lymphocyte count or total leucocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid

Fee: \$104.75 **Benefit:** 75% = \$78.60 85% = \$89.05

71141

Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens

Fee: \$198.70 **Benefit:** 75% = \$149.05 85% = \$168.90

71143

Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or both of items 71139 and 71141 (if performed), on a specimen of blood, CSF, serous fluid or disaggregated tissue

Fee: \$261.75 **Benefit:** 75% = \$196.35 85% = \$222.50

71145

Characterisation of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations for the diagnosis (but not monitoring) of an immunological or haematological malignancy, including a service described in 1 or more of items 71139, 71141 and 71143 (if performed), on 2 or more specimens of disaggregated tissues or 1 specimen of disaggregated tissue and 1 or more specimens of blood, CSF or serous fluid

Fee: \$427.35 **Benefit:** 75% = \$320.55 85% = \$363.25

71146

Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count on the pheresis collection

Fee: \$104.75 **Benefit:** 75% = \$78.60 85% = \$89.05

71147

HLA-B27 typing

(Item is subject to rule 27)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

71148

A test described in item 71147 if rendered by a receiving APP.

(Item is subject to rule 18 and 27)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

71149

Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including (if performed) a service described in item 71147

Fee: \$109.00 **Benefit:** 75% = \$81.75 85% = \$92.65

71151

Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens

Fee: \$119.65 **Benefit:** 75% = \$89.75 85% = \$101.75

71153

Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis - antineutrophil cytoplasmic antibody immunofluorescence (ANCA test), antineutrophil proteinase 3 antibody (PR-3 ANCA test), antimyeloperoxidase antibody (MPO ANCA test) or anti-glomerular basement membrane antibody (GBM test) - detection of 1 antibody

(Item is subject to rule 6 and 23)

Fee: \$34.80 **Benefit:** 75% = \$26.10 85% = \$29.60

71154

A test described in item 71153, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test.

(Item is subject to rule 6, 18 and 23)

Fee: \$34.80 **Benefit:** 75% = \$26.10 85% = \$29.60

71155

Detection of 2 antibodies described in item 71153

(Item is subject to rule 6 and 23)

Fee: \$47.75 **Benefit:** 75% = \$35.85 85% = \$40.60

71156

Tests described in item 71153, other than that described in 71154, if rendered by a receiving APP - each test to a maximum of 3 tests

(Item is subject to rule 6, 18 and 23)

Fee: \$12.95 **Benefit:** 75% = \$9.75 85% = \$11.05

71157

Detection of 3 antibodies described in item 71153

(Item is subject to rule 6 and 23)

Fee: \$60.70 **Benefit:** 75% = \$45.55 85% = \$51.60

71159

Detection of 4 or more antibodies described in item 71153

(Item is subject to rule 6 and 23)

Fee: \$73.65 **Benefit:** 75% = \$55.25 85% = \$62.65

71163

Detection of one of the following antibodies (of 1 or more class or isotype) in the assessment or diagnosis of coeliac disease or other gluten hypersensitivity syndromes and including a service described in item 71066 (if performed):

- a) Antibodies to gliadin; or
- b) Antibodies to endomysium; or
- c) Antibodies to tissue transglutaminase;

- 1 test

Fee: \$24.90 **Benefit:** 75% = \$18.70 85% = \$21.20

71164

Two or more tests described in 71163 and including a service described in 71066 (if performed)

Fee: \$40.15 **Benefit:** 75% = \$30.15 85% = \$34.15

71165

Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome or thyroid stimulating hormone receptor) - detection, including quantitation if required, of 1 antibody

(Item is subject to rule 6)

Fee: \$34.80 **Benefit:** 75% = \$26.10 85% = \$29.60

71166

Detection of 2 antibodies described in item 71165

(Item is subject to rule 6)

Fee: \$47.75 **Benefit:** 75% = \$35.85 85% = \$40.60

71167

Detection of 3 antibodies described in item 71165

(Item is subject to rule 6)

Fee: \$60.70 **Benefit:** 75% = \$45.55 85% = \$51.60

71168

Detection of 4 or more antibodies described in item 71165

(Item is subject to rule 6)

Fee: \$73.65 **Benefit:** 75% = \$55.25 85% = \$62.65

71169

A test described in item 71165, if rendered by a receiving APP, where no tests in the item have been rendered by the referring APP - 1 test

(Item is subject to rule 6 and 18)

Fee: \$34.80 **Benefit:** 75% = \$26.10 85% = \$29.60

71170

Tests described in item 71165, other than that described in 71169, if rendered by a receiving APP - each test to a maximum of 3 tests

(Item is subject to rule 6 and 18)

Fee: \$12.95 **Benefit:** 75% = \$9.75 85% = \$11.05

71180

Antibody to cardiolipin or beta-2 glycoprotein I - detection, including quantitation if required; one antibody specificity (IgG or IgM)

Fee: \$34.80 **Benefit:** 75% = \$26.10 85% = \$29.60

71183

Detection of two antibodies described in item 71180

Fee: \$47.75 **Benefit:** 75% = \$35.85 85% = \$40.60

71186

Detection of three or more antibodies described in item 71180

Fee: \$60.70 **Benefit:** 75% = \$45.55 85% = \$51.60

71189

Detection of specific IgG antibodies to 1 or more respiratory disease allergens not elsewhere specified.

Fee: \$15.60 **Benefit:** 75% = \$11.70 85% = \$13.30

71192

2 items described in item 71189.

Fee: \$28.55 **Benefit:** 75% = \$21.45 85% = \$24.30

71195

3 or more items described in item 71189.

Fee: \$40.30 **Benefit:** 75% = \$30.25 85% = \$34.30

71198

Estimation of serum tryptase for the evaluation of unexplained acute hypotension or suspected anaphylactic event, assessment of risk in stinging insect anaphylaxis, exclusion of mastocytosis, monitoring of known mastocytosis.

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

71200

Detection and quantitation, if present, of free kappa and lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias.

Fee: \$60.00 **Benefit:** 75% = \$45.00 85% = \$51.00

71203

Determination of HLAB5701 status by flow cytometry or cytotoxicity assay prior to the initiation of Abacavir therapy including item 73323 if performed.

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

72813

Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens

(Item is subject to rule 13)

Fee: \$72.00 **Benefit:** 75% = \$54.00 85% = \$61.20

72816

Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen

(Item is subject to rule 13)

Fee: \$86.95 **Benefit:** 75% = \$65.25 85% = \$73.95

72817

Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens

(Item is subject to rule 13)

Fee: \$97.45 **Benefit:** 75% = \$73.10 85% = \$82.85

72818

Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens

(Item is subject to rule 13)

Fee: \$107.75 **Benefit:** 75% = \$80.85 85% = \$91.60

72823

Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen

(Item is subject to rule 13)

Fee: \$97.80 **Benefit:** 75% = \$73.35 85% = \$83.15

72824

Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens

(Item is subject to rule 13)

Fee: \$142.30 **Benefit:** 75% = \$106.75 85% = \$121.00

72825

Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 to 7 separately identified specimens

(Item is subject to rule 13)

Fee: \$181.45 **Benefit:** 75% = \$136.10 85% = \$154.25

72826

Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 8 to 11 separately identified specimens

(Item is subject to rule 13)

Fee: \$195.90 **Benefit:** 75% = \$146.95 85% = \$166.55

72827

Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 12 to 17 separately identified specimens

(Item is subject to Rule 13)

Fee: \$210.35 **Benefit:** 75% = \$157.80 85% = \$178.80

72828

Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 18 or more separately identified specimens

(Item is subject to Rule 13)

Fee: \$224.80 **Benefit:** 75% = \$168.60 85% = \$191.10

72830

Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens

(Item is subject to rule 13)

Fee: \$276.00 **Benefit:** 75% = \$207.00 85% = \$234.60

72836

Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens

(Item is subject to rule 13)

Fee: \$420.00 **Benefit:** 75% = \$315.00 85% = \$357.00

72838

Examination of complexity level 7 biopsy material with multiple tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens.

(Item is subject to rule 13)

Fee: \$470.00 **Benefit:** 75% = \$352.50 85% = \$399.50

72844

Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests

Fee: \$30.95 **Benefit:** 75% = \$23.25 85% = \$26.35

72846

Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 72848

(Item is subject to rule 13)

Fee: \$60.00 **Benefit:** 75% = \$45.00 85% = \$51.00

72847

Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4-6 antibodies

(Item is subject to rule 13)

Fee: \$90.00 **Benefit:** 75% = \$67.50 85% = \$76.50

72848

Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2)

(Item is subject to rule 13)

Fee: \$75.00 **Benefit:** 75% = \$56.25 85% = \$63.75

72849

Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 7-10 antibodies

(Item is subject to rule 13)

Fee: \$105.00 **Benefit:** 75% = \$78.75 85% = \$89.25

72850

Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies

(Item is subject to rule 13)

Fee: \$120.00 **Benefit:** 75% = \$90.00 85% = \$102.00

72851

Electron microscopic examination of biopsy material - 1 separately identified specimen

(Item is subject to rule 13)

Fee: \$185.60 **Benefit:** 75% = \$139.20 85% = \$157.80

72852

Electron microscopic examination of biopsy material - 2 or more separately identified specimens

(Item is subject to rule 13)

Fee: \$247.45 **Benefit:** 75% = \$185.60 85% = \$210.35

72855

Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 1 separately identified specimen

(Item is subject to rule 13)

Fee: \$185.60 **Benefit:** 75% = \$139.20 85% = \$157.80

72856

Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 2 to 4 separately identified specimens

(Item is subject to rule 13)

Fee: \$247.45 **Benefit:** 75% = \$185.60 85% = \$210.35

72857

Intraoperative consultation and examination of biopsy material by frozen section or tissue imprint or smear - 5 or more separately identified specimens

(Item is subject to rule 13)

Fee: \$288.70 **Benefit:** 75% = \$216.55 85% = \$245.40

73043

Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests

Fee: \$23.00 **Benefit:** 75% = \$17.25 85% = \$19.55

73045

Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on:

- (a) specimens resulting from washings or brushings from sites not specified in item 73043; or
- (b) a single specimen of sputum or urine; or
- (c) 1 or more specimens of other body fluids;

1 or more tests

Fee: \$48.95 **Benefit:** 75% = \$36.75 85% = \$41.65

73047

Cytology of a series of 3 sputum or urine specimens for malignant cells

Fee: \$95.35 **Benefit:** 75% = \$71.55 85% = \$81.05

73049

Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 1 identified site

Fee: \$68.60 **Benefit:** 75% = \$51.45 85% = \$58.35

73051

Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if a recognized pathologist:

- (a) performs the aspiration; or
- (b) attends the aspiration and performs cytological examination during the attendance

Fee: \$171.50 **Benefit:** 75% = \$128.65 85% = \$145.80

73053

Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination

- (a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or
- (b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a); or
- (c) if there is inadequate information provided to use item 73055;

(See para [P16.11](#) of explanatory notes to this Category)

Fee: \$19.60 **Benefit:** 75% = \$14.70 85% = \$16.70

73055

Cytology of a smear from cervix, not associated with item 73053, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test

- (a) for the management of previously detected abnormalities including precancerous or cancerous conditions; or
- (b) for the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia;

(See para [P16.11](#) of explanatory notes to this Category)

Fee: \$19.60 **Benefit:** 75% = \$14.70 85% = \$16.70

73057

Cytology of smears from vagina, not associated with item 73053 or 73055 and not to monitor hormone replacement therapy, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test

(See para [P16.11](#) of explanatory notes to this Category)

Fee: \$19.60 **Benefit:** 75% = \$14.70 85% = \$16.70

73059

Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies except those listed in 73061

(Item is subject to rule 13)

Fee: \$43.30 **Benefit:** 75% = \$32.50 85% = \$36.85

73060

Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 to 6 antibodies

(Item is subject to rule 13)

Fee: \$57.75 **Benefit:** 75% = \$43.35 85% = \$49.10

73061

Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 of the following antibodies - oestrogen, progesterone and c-erb-B2 (HER2)

(Item is subject to rule 13)

Fee: \$51.55 **Benefit:** 75% = \$38.70 85% = \$43.85

73062

Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues - 2 or more separately identified sites.

Fee: \$89.60 **Benefit:** 75% = \$67.20 85% = \$76.20

73063

Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy

Fee: \$100.00 **Benefit:** 75% = \$75.00 85% = \$85.00

73064

Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 7 to 10 antibodies

(Item is subject to rule 13)

Fee: \$72.20 **Benefit:** 75% = \$54.15 85% = \$61.40

73065

Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049, 73051, 73062 and 73063 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 11 or more antibodies

(Item is subject to rule 13)

Fee: \$86.60 **Benefit:** 75% = \$64.95 85% = \$73.65

73066

Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if a recognized pathologist:

- (a) performs the aspiration; or
- (b) attends the aspiration and performs cytological examination during the attendance

Fee: \$222.95 **Benefit:** 75% = \$167.25 85% = \$189.55

73067

Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy

Fee: \$130.00 **Benefit:** 75% = \$97.50 85% = \$110.50

73287

The study of the whole of every chromosome by cytogenetic or other techniques, performed on 1 or more of any tissue or fluid except blood (including a service mentioned in item 73293, if performed) - 1 or more tests

Fee: \$397.20 **Benefit:** 75% = \$297.90 85% = \$337.65

73289

The study of the whole of every chromosome by cytogenetic or other techniques, performed on blood (including a service mentioned in item 73293, if performed) - 1 or more tests

Fee: \$361.35 **Benefit:** 75% = \$271.05 85% = \$307.15

73290

The study of the whole of each chromosome by cytogenetic or other techniques, performed on blood or bone marrow, in the diagnosis and monitoring of haematological malignancy (including a service in items 73287 or 73289, if performed). - 1 or more tests.

Fee: \$397.20 **Benefit:** 75% = \$297.90 85% = \$337.65

73291

Analysis of one or more chromosome regions for specific constitutional genetic abnormalities of blood or fresh tissue in

- a) diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities, in whom cytogenetic studies (item 73287 or 73289) are either normal or have not been performed; or
- b) studies of a relative for an abnormality previously identified in such an affected person.

- 1 or more tests.

Fee: \$232.50 **Benefit:** 75% = \$174.40 85% = \$197.65

73292

Analysis of chromosomes by genome-wide micro-array including targeted assessment of specific regions for constitutional genetic abnormalities in diagnostic studies of a person with developmental delay, intellectual disability, autism, or at least two congenital abnormalities (including a service in items 73287, 73289 or 73291, if performed)

- 1 or more tests.

Fee: \$593.85 **Benefit:** 75% = \$445.40 85% = \$522.65

73293

Analysis of one or more regions on all chromosomes for specific constitutional genetic abnormalities of fresh tissue in diagnostic studies of the products of conception, including exclusion of maternal cell contamination.

- 1 or more tests.

Fee: \$232.50 **Benefit:** 75% = \$174.40 85% = \$197.65

73294

Analysis of the PMP22 gene for constitutional genetic abnormalities causing peripheral neuropathy, either as:

- a) diagnostic studies of an affected person; or
- b) studies of a relative for an abnormality previously identified in an affected person

- 1 or more tests.

Fee: \$232.50 **Benefit:** 75% = \$174.40 85% = \$197.65

73300

Detection of mutation of the FMR1 gene where:

- (a) the patient exhibits intellectual disability, ataxia, neurodegeneration, or premature ovarian failure consistent with an FMRI mutation; or
- (b) the patient has a relative with a FMR1 mutation

1 or more tests

Fee: \$102.00 **Benefit:** 75% = \$76.50 85% = \$86.70

73305

Detection of mutation of the FMR1 gene by Southern Blot analysis where the results in item 73300 are inconclusive

(See para [P16.12](#) of explanatory notes to this Category)

Fee: \$204.00 **Benefit:** 75% = \$153.00 85% = \$173.40

73308

Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of the other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests

Fee: \$36.70 **Benefit:** 75% = \$27.55 85% = \$31.20

73309

A test described in item 73308, if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$36.70 **Benefit:** 75% = \$27.55 85% = \$31.20

73311

Characterisation of the genotype of a person who is a first degree relative of a person who has proven to have 1 or more abnormal genotypes under item 73308 - 1 or more tests

Fee: \$36.70 **Benefit:** 75% = \$27.55 85% = \$31.20

73312

A test described in item 73311, if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$36.70 **Benefit:** 75% = \$27.55 85% = \$31.20

73314

Characterisation of gene rearrangement or the identification of mutations within a known gene rearrangement, in the diagnosis and monitoring of patients with laboratory evidence of:

- (a) acute myeloid leukaemia; or
- (b) acute promyelocytic leukaemia; or
- (c) acute lymphoid leukaemia; or
- (d) chronic myeloid leukaemia;

Fee: \$232.50 **Benefit:** 75% = \$174.40 85% = \$197.65

73315

A test described in item 73314, if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18)

Fee: \$232.50 **Benefit:** 75% = \$174.40 85% = \$197.65

73317

Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where:

- (a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or
- (b) the patient has a first degree relative with haemochromatosis; or
- (c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis

(Item is subject to rule 20)

Fee: \$36.70 **Benefit:** 75% = \$27.55 85% = \$31.20

73318

A test described in item 73317, if rendered by a receiving APP - 1 or more tests

(Item is subject to rule 18 and 20)

Fee: \$36.70 **Benefit:** 75% = \$27.55 85% = \$31.20

73320

Detection of HLA-B27 by nucleic acid amplification

includes a service described in 71147 unless the service in item 73320 is rendered as a pathologist determinable service.

(Item is subject to rule 27)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

73321

A test described in item 73320, if rendered by a receiving APP - 1 or more tests.

(Item is subject to rule 18 and 27)

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

73323

Determination of HLAB5701 status by molecular techniques prior to the initiation of Abacavir therapy including item 71203 if performed.

Fee: \$40.80 **Benefit:** 75% = \$30.60 85% = \$34.70

73324

A test described in item 73323 if rendered by a receiving APP

1 or more tests

(Item is subject to Rule 18)

Fee: \$41.25 **Benefit:** 75% = \$30.95 85% = \$35.10

73325

Characterisation of mutations in:

- (a) the JAK2 gene; or
- (b) the MPL gene; or
- (c) both genes;

in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of:

- a) polycythaemia vera; or
- b) essential thrombocythaemia;

1 or more tests

Fee: \$75.00 **Benefit:** 75% = \$56.25 85% = \$63.75

73326

Characterisation of the gene rearrangement FIP1L1-PDGFR α in the diagnostic work-up and management of a patient with laboratory evidence of:

- a) mast cell disease; or
- b) idiopathic hypereosinophilic syndrome; or
- c) chronic eosinophilic leukaemia;.

1 or more tests

Fee: \$232.50 **Benefit:** 75% = \$174.40 85% = \$197.65

73327

Detection of genetic polymorphisms in the Thiopurine S-methyltransferase gene for the prevention of dose-related toxicity during treatment with thiopurine drugs; including (if performed) any service described in item 65075.

1 or more tests

Fee: \$52.30 **Benefit:** 75% = \$39.25 85% = \$44.50

73521

Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test)

Fee: \$9.75 **Benefit:** 75% = \$7.35 85% = \$8.30

73523

Semen examination (other than post-vasectomy semen examination), including:

- (a) measurement of volume, sperm count and motility; and
- (b) examination of stained preparations; and
- (c) morphology; and (if performed)
- (d) differential count and 1 or more chemical tests;

(Item is subject to rule 25)

Fee: \$42.05 **Benefit:** 75% = \$31.55 85% = \$35.75

73525

Sperm antibodies - sperm-penetrating ability - 1 or more tests

Fee: \$28.55 **Benefit:** 75% = \$21.45 85% = \$24.30

73527

Human chorionic gonadotrophin (HCG) - detection in serum or urine by 1 or more methods for diagnosis of pregnancy - 1 or more tests

Fee: \$10.05 **Benefit:** 75% = \$7.55 85% = \$8.55

73529

Human chorionic gonadotrophin (HCG), quantitation in serum by 1 or more methods (except by latex, membrane, strip or other pregnancy test kit) for diagnosis of threatened abortion, or followup of abortion or diagnosis of ectopic pregnancy, including any services performed in item 73527 - 1 test

Fee: \$28.85 **Benefit:** 75% = \$21.65 85% = \$24.55

73801

Semen examination for presence of spermatozoa

Fee: \$6.95 **Benefit:** 75% = \$5.25 85% = \$5.95

73802

Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test

Fee: \$4.60 **Benefit:** 75% = \$3.45 85% = \$3.95

73803

2 tests described in item 73802

Fee: \$6.40 **Benefit:** 75% = \$4.80 85% = \$5.45

73804

3 or more tests described in item 73802

Fee: \$8.20 **Benefit:** 75% = \$6.15 85% = \$7.00

73805

Microscopy of urine, whether stained or not, or catalase test

Fee: \$4.60 **Benefit:** 75% = \$3.45 85% = \$3.95

73806

Pregnancy test by 1 or more immunochemical methods

Fee: \$10.20 **Benefit:** 75% = \$7.65 85% = \$8.70

73807

Microscopy for wet film other than urine, including any relevant stain

Fee: \$6.95 **Benefit:** 75% = \$5.25 85% = \$5.95

73808

Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807

Fee: \$8.70 **Benefit:** 75% = \$6.55 85% = \$7.40

73809

Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method

Fee: \$2.35 **Benefit:** 75% = \$1.80 85% = \$2.00

73810

Microscopy for fungi in skin, hair or nails - 1 or more sites

Fee: \$6.95 **Benefit:** 75% = \$5.25 85% = \$5.95