Australian Government

Department of Health and Ageing

Medicare Benefits Schedule July 2007 Supplement

Department of Health and Ageing

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IMPORTANT INFORMATION:

This document is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

At the time of production of this document, the relevant legislation giving authority for the changes included in this edition are still subject to the approval of Executive Council and Parliamentary scrutiny.

Please note that if the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 July 2007 and continues beyond that date, the existing item, fee and benefit levels will apply. In any other case the date the service is rendered will determine which item and fee is applicable.

MBS Online

The latest Medicare Benefits Schedule information is available from *MBS Online* at:

http://www.health.gov.au/mbsonline

MBS Online recently introduced a Subscription service that is proving to be a useful tool to many subscribers. This service notifies subscribers when amendments have been made to the Medicare Benefits Schedule. MBS Online currently has over 1,000 subscribers.

The Department welcomes any suggestions for improvements to MBS Online as well as the layout of the Medicare Benefits Schedule book and online documents. Any suggestions should be sent to:

Contact Details	
email	**mbsonline@health.gov.au**
Correspondence	MBS Online Team Australian Government Department of Health and Ageing MDP 106 GPO BOX 9848

Interpretation of the MBS

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 enquiries relating to the MBS:

NSW – 02 9895 3346

WA - 08 9214 8488

VIC - 03 9605 7964

TAS - 03 6215 5740

QLD - 07 3004 5450

ACT - 02 6124 6362

SA - 08 8274 9788

NT - use South Australia number

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AMENDMENTS EFFECTIVE 1 JULY 2007

Annual health assessment for people with an intellectual disability

Items 718 and 719 will support general practitioners (GPs) to identify and address the specific clinical needs of patients who have an intellectual disability. See Note A.27 below.

Wound Management services provided by a practice nurse

Explanatory Note M.2.15 (relating to item 10996) clarifies that it is acceptable for the initial assessment of the patient's wound may be undertaken by the medical practitioner under a distance supervision arrangement if the medical practitioner is not physically present. This brings this item in to line with existing arrangements for wound management services provided by a registered Aboriginal Health Worker. See Note M.2.15 below.

Services provided by a Practice Nurse or Aboriginal Health Worker

Item 10997 has been introduced to provide an MBS rebate for practice nurses and registered Aboriginal Health Workers to provide ongoing support and monitoring for patients with chronic diseases for and on behalf of general practitioners. This will assist patients who require access to ongoing care, frequently for relatively routine treatment and ongoing monitoring and support between more structured reviews of a care plan by the patient's GP.

Brachytherapy

Items 15338 and 37220 are being amended to increase the upper Gleason Score for prostatic malignancy from 6 to 7 following a recommendation that was made by the Medical Services Advisory Committee.

Double Balloon Enteroscopy of the Small Bowel

Following a recommendation of the Medical Services Advisory Committee (MSAC), items 30680-30686 have been introduced for use of this procedure in the diagnosis and management of patients with obscure gastrointestinal bleeding. Item 11820 (capsule endoscopy) has been amended to clarify that it does not cover double balloon enteroscopy.

Endoscopic Ultrasound

Following a recommendation of the Medical Services Advisory Committee (MSAC), items 30688-30694 have been introduced for use of this procedure (with or without fine needle aspiration) in the staging and diagnosis of patients with specified gastrointestinal neoplasms.

Plastic and Reconstructive Surgery

Explanatory note T8.102 (formerly Note T8.100), as applying to items 45552-45555, has been amended to reflect that in general it is expected that the replacement prosthesis will be the same size as the prosthesis removed, however, in situations arising from medical complications, it is appropriate to use a different size prosthesis.

CTC Colonography

The Radiology Management Committee (RMC), which manages the Radiology Quality and Outlays Memorandum of Understanding, has determined that interim items 56549 and 56551 for CT Colonography (known as CTC) be replaced by two new items 56552 and 56554. The new CTC items include new fees and conditions for service.

SUMMARY OF CHANGES

The 1 July 2007 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number:-

† new item

‡ amended description

+ amended fee

New Items

718 719 10997 30680 30682 30684 30686
30688 30690 30692 30694 56552 56554

Deleted Items

56549 56551

Amended Description

11820 15338 37220

Services that attract the 100% Medicare rebate

Medicare Benefits Schedule (MBS) Group	Name of Group	Item numbers
Group A1 *(all items other than items 19, 33, 40, 50)*	General practitioner attendances to which no other item applies	1, 2, 601, 602, 3, 4, 13, 20, 23, 24, 25, 35, 36, 37, 38, 43, 44, 47, 48, 51
Group A2 *(all items other than items 87, 89, 90, 91)*	Other non-referred attendances to which no other item applies	52, 53, 54, 57, 58, 59, 60, 65, 81, 83, 84, 86, 92, 93, 95, 96, 97, 98, 697, 698
Group A5	Prolonged attendances to which no other item applies	160, 161, 162, 163, 164
Group A6	Group therapy	170, 171, 172
Group A7	Acupuncture	173, 193, 195, 197, 199
Group A14	Health assessments	700, 702, 704, 706, 708, 710, 712, 714, 716, 717, 718, 719
Group A15 *(all items other than items 746, 749, 757, 768, 771, 773, 820-866)*	Multidisciplinary care plans and multidisciplinary case conferences	721, 723, 725, 727, 729, 731, 734, 736, 738, 740, 742, 744, 759, 762, 765, 775, 778, 779
Group A17	Medication management review	900, 903
Group A18	General practitioner attendances associated with Practice Incentives Program (PIP) payments	2497, 2501, 2503, 2504, 2506, 2507, 2509, 2517, 2518, 2521, 2522, 2525, 2526, 2546, 2547, 2552, 2553, 2558, 2559
Group A19	Other non-referred attendances associated with Practice Incentives Program (PIP) payments to which no other item applies	2598, 2600, 2603, 2606, 2610, 2613, 2616, 2620, 2622, 2624, 2631, 2633, 2635, 2664, 2666, 2668, 2673, 2675, 2677
Group A20	GP mental health care	2710, 2712, 2713, 2721, 2723, 2725, 2727
Group A27	Pregnancy support counselling	4001
Group A22	General practitioner after-hours attendances to which no other item applies	5000, 5003, 5007, 5010, 5020, 5023, 5026, 5028, 5040, 5043, 5046, 5049, 5060, 5063, 5064, 5067
Group A23	Other non-referred after-hours attendances to which no other item applies	5200, 5203, 5207, 5208, 5220, 5223, 5227, 5228, 5240, 5243, 5247, 5248, 5260, 5263, 5265, 5267
Group M2	Services provided by a practice nurse on behalf of a medical practitioner	10993, 10994, 10995, 10996, 10997, 10998, 10999
Group M5	Services provided by a registered Aboriginal Health Worker on behalf of a medical practitioner	10988, 10989

	GROUP A14 - HEALTH ASSESSMENTS
† **718**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) **AT CONSULTING ROOMS** for a health assessment - of a patient with an intellectual disability – not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 719**. *(See para A.27 of explanatory notes to this Category)* **Fee:** $199.60 **Benefit:** 100% = $199.60
† **719**	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician**) NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY** for a health assessment - of a patient with an intellectual disability - not being a health assessment for a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or **item 718.** *(See para A.27 of explanatory notes to this Category)* **Fee:** $222.05 **Benefit:** 100% = $222.05
	GROUP M2 - SERVICES PROVIDED BY A PRACTICE NURSE ON BEHALF OF A MEDICAL PRACTITIONER
† **10997**	Service provided to a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker if: (a) the service is provided on behalf of and under the supervision of a medical practitioner; and (b) the person is not an admitted patient of a hospital; and (c) the person has a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan in place; and (d) the service is consistent with the GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan to a maximum of 5 services per patient in a calendar year *(See para M.2 of explanatory notes to this Category)* **Fee:** $10.60 **Benefit:** 100% = $10.60

DIAGNOSTIC	GASTROENTEROLOGY & COLORECTAL

	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
	CAPSULE ENDOSCOPY to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered), (not being a service associated with double balloon enteroscopy), if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the patient to whom the service is provided: (i) is aged 10 years or over; and (ii) has recurrent or persistent bleeding; and (iii) is anaemic or has active bleeding; and (c) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (d) the service is performed within 6 months of the upper gastrointestinal endoscopy and colonoscopy
ǂ	*(See para D1.22 of explanatory notes to this Category)*
11820	**Fee:** $1,801.90 **Benefit:** 75% = $1,351.45 85% = $1,738.00

RADIATION ONCOLOGY	BRACHYTHERAPY

	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 4 - BRACHYTHERAPY
	PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist.
ǂ	*(See para T2.3 of explanatory notes to this Category)*
15338	**Fee:** $826.70 **Benefit:** 75% = $620.05 85% = $762.80

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
† **30680**	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) **Fee:** $1,033.90 **Benefit:** 75% = $775.45 85% = $970.00
† **30682**	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITHOUT intraprocedural therapy, for diagnosis of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) **Fee:** $1,033.90 **Benefit:** 75% = $775.45 85% = $970.00

† **30684**	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (oral approach), with or without biopsy, WITH 1 or more of the following procedures (polypectomy, snares, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30682 or 30686) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) **Fee:** $1,272.30 **Benefit:** 75% = $954.25 85% = $1,208.40
† **30686**	DOUBLE BALLOON ENTEROSCOPY, examination of the small bowel (anal approach), with or without biopsy, WITH 1 or more of the following procedures (polypectomy, snares, removal of foreign body, diathermy, heater probe or laser coagulation), for diagnosis and management of patients with obscure gastrointestinal bleeding, not in association with another item in this subgroup (with the exception of item 30680 or 30684) The patient to whom the service is provided must: (i) have recurrent or persistent bleeding; and (ii) be anaemic or have active bleeding; and (iii) have had an upper gastrointestinal endoscopy and a colonoscopy performed which did not identify the cause of the bleeding. (Anaes.) **Fee:** $1,272.30 **Benefit:** 75% = $954.25 85% = $1,208.40
† **30688**	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging)), with or without biopsy, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $322.45 **Benefit:** 75% = $241.85 85% = $274.10

† **30690**	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION, including aspiration of the locoregional lymph nodes if performed, for the staging of 1 or more of oesophageal, gastric or pancreatic cancer, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $497.75 **Benefit:** 75% = $373.35 85% = $433.85
† **30692**	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $322.45 **Benefit:** 75% = $241.85 85% = $274.10
† **30694**	ENDOSCOPIC ULTRASOUND (endoscopy with ultrasound imaging), with or without biopsy, WITH FINE NEEDLE ASPIRATION for the diagnosis of 1 or more of pancreatic, biliary or gastric submucosal tumours, not in association with another item in this Subgroup and not being a service associated with the routine monitoring of chronic pancreatitis. (Anaes.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $497.75 **Benefit:** 75% = $373.35 85% = $433.85
	SUBGROUP 5 - UROLOGICAL
‡ **37220**	PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1 (clinically inapparent tumour not palpable or visible by imaging) or T2 (tumour confined within prostate), with a Gleason score of less than or equal to 7 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. *(See para T8.58 of explanatory notes to this Category)* **Fee:** $922.70 **Benefit:** 75% = $692.05

	GROUP I2 - COMPUTED TOMOGRAPHY
	COMPUTED TOMOGRAPHY OF COLON for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the patient has had an incomplete colonoscopy in the 3 months before the scan; and (b) the date of incomplete colonoscopy is set out on the request for scan; and (c) the service is not a service to which items 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K)
†	(Anaes.)
56552	*(See para DIL of explanatory notes to this Category)*
	Fee: $600.00 **Benefit:** 75% = $450.00 85% = $536.10
	COMPUTED TOMOGRAPHY OF COLON for exclusion of colorectal neoplasia in symptomatic or high risk patients if: (a) the request for scan states that one of the following contraindications to colonoscopy is present: (i) suspected perforation of the colon; (ii) complete or high-grade obstruction that will not allow passage of the scope; and (b) the service must not be a service to which item 56301, 56307, 56401, 56407, 56409, 56412, 56501, 56507, 56801, 56807 or 57001 applies (R) (K)
†	(Anaes.)
56554	*(See para DIL of explanatory notes to this Category)*
	Fee: $600.00 **Benefit:** 75% = $450.00 85% = $536.10

A.27 ANNUAL HEALTH ASSESSMENT FOR PEOPLE WITH AN INTELLECTUAL DISABILITY (ITEMS 718 AND 719)

The purpose of the health assessment is to support general practitioners (GPs) to identify and address the specific clinical needs of patients who have an intellectual disability.

A.27.1 The health assessment does not apply to in-patients of a hospital, day hospital facility or residential aged care facility.

A.27.2 For the health assessment a person will be deemed to have an intellectual disability if they have significantly sub-average general intellectual functioning (two standard deviations below the average intelligence quotient (IQ)) and would benefit from assistance with daily living activities. Where GPs wish to confirm intellectual disability and a patient's need for assistance with activities of daily living, they may seek verification from a paediatrician registered to practice in Australia or from a government-provided or funded disability service that has assessed the patient's intellectual function.

A.27.3 The aim of the health assessment is to provide a structured clinical framework for GPs to comprehensively assess the physical, psychological and social function of patients with an intellectual disability and to identify any medical intervention and preventative health care required. If an assessment identifies that a patient has a chronic medical condition and complex care needs, it may be appropriate to involve other health professionals in the patient's care using the Enhanced Primary Care (EPC) Chronic Disease Management (CDM) items for GP Management Plans and Team Care Arrangements (see items 721-731).

A.27.4 The health assessment can be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician. In these notes, the term 'GP' is used as a generic reference to a medical practitioner able to claim this item.

A.27.5 The health assessment should generally be undertaken by the patient's 'usual doctor', that is, the GP (or a GP in the same practice) who has provided the majority of services to the patient in the past 12 months, and/or is likely to provide the majority of services in the following 12 months.

A.27.6 The information collection component of the assessment may be rendered by a nurse or other health professional in accordance with accepted medical practice, acting under the supervision of the GP. The other components of the health assessment must include a personal attendance by the GP.

A.27.7 For the purposes of the previous paragraph, the services of a third party service provider such as a nurse or other health professional may only be used to assist in the information collection component of health assessments where:

a) Use of the third party service provider is initiated by the patient's GP, after the patient has agreed to a health assessment and to the use of a third party to collect information for the assessment;

b) The patient is made aware whether information collected about them for the health assessment

will be retained by the third party service provider; and

c) The third party service provider must act under the supervision of the practitioner. The practitioner should:

- be satisfied that the third party service provider has the necessary skills, expertise and training to collect the information required for the health assessment;
- have established how the information is to be collected and recorded (including any forms used);
- set or approve the quality assurance procedures for the information collection;
- be consulted on any issues arising during the information collection; and
- review and analyse the information collected to prepare their report of the health assessment and communicate to the patient their recommendations about matters covered by the health assessment.

A.27.8 The health assessment must include the following items as relevant to the patient:

a) Check dental health (including dentition);

b) Conduct aural examination (arrange formal audiometry if audiometry has not been conducted within 5 years);

c) Assess ocular health (arrange review by an ophthalmologist or optometrist if a comprehensive eye examination has not been conducted within 5 years);

d) Assess nutritional status (including weight and height measurements) and a review of growth and development;

e) Assess bowel and bladder function (particularly for incontinence or chronic constipation);

f) Assess medications (including non-prescription medicines taken by the patient, prescriptions from other doctors, medications prescribed but not taken, interactions, side effects and review of indications);

- Advise carers of the common side effects and interactions.
- Consider the need for a formal medication review.

g) Check immunisation status, including influenza, tetanus, hepatitis A and B, Measles, Mumps and Rubella (MMR) and pneumococcal vaccinations;

- Refer to the current Australian Standard Vaccination Schedule (a National Health and Medical Research Council document) for appropriate vaccination schedules;

h) Check exercise opportunities (with the aim of moderate exercise for at least 30 minutes per day);

i) Check whether the support provided for activities of daily living adequately and appropriately meets the patient's needs, and consider formal review if required;

j) Consider the need for breast examination, mammography, Papanicolaou smears, testicular examination, lipid measurement and prostate assessment as for the general population;

k) Check for dysphagia and gastro-oesophageal disease (especially for patients with cerebral palsy), and arrange for investigation or treatment as required;

l) Assess risk factors for osteoporosis (including diet, exercise, Vitamin D deficiency, hormonal status, family history, medication fracture history) and arrange for investigation or treatment as required;

m) For patients diagnosed with epilepsy, review of seizure control (including anticonvulsant drugs) and consider referral to a neurologist at appropriate intervals;

n) Screen for thyroid disease at least every two years (or yearly for patients with Down syndrome);

o) For patients without a definitive aetiological diagnosis, consider referral to a genetic clinic every 5 years;

p) Assess or review treatment for comorbid mental health issues;

q) Consider timing of puberty and management of sexual development, sexual activity and reproductive health; and

r) Consider whether there are any signs of physical, psychological or sexual abuse.

A.27.9 The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should also consider the following:

Medical

Health Problems identified

Follow up consultation should be arranged to determine further management when the assessment identifies issues requiring medical treatment such as high blood pressure, or clinical examination reveals likelihood of other potential health problem(s).

Continence

Continence problems are a major cause of reduced quality of life for people with an intellectual disability and are frequently amenable to improved management. Carers should be asked if there are problems and assessment should be directed at the underlying pathology.

Physical function

Activities of daily living

Patients are only eligible for the health assessment where they would benefit from assistance with activities of daily living. The assessment should consider the health impact of the patient's general skill levels (including independent living skills). The patient's daily activities also include access to transport.

The assessment should consider whether a referral for a formal review of activities of daily living is required. Assessment of activities of daily living is concerned with the interaction between the patient, their impairment (if any) and their environment. This would include an assessment of the patient's ability to transfer between bed, chair and toilet, attend to their personal hygiene, dress, prepare food and eat.

Psychological function

Cognition

People with intellectual disability can have dementia and it is particularly common in people with Down syndrome. Detailed diagnosis can often improve quality of life. Where problems with cognition and skill decline are clinically suspected, medical and psychiatric causes should be considered and investigated.

Mood

Depression is common in people with intellectual disability but diagnosis can be difficult. Depression should be considered where there is a history of weight change, changes in sleep habit and escalation of behavioural problems.

Behaviour

Behavioural problems are common in people with intellectual disability. With the review it is important to keep track of the patient's current behavioural status and where indicated ensure that there are systems in place that provide an objective measure of that status.

Psychiatric Symptoms

Psychiatric disorders occur more commonly in people with intellectual disability and are often more difficult to diagnose or distinguish from a reaction to that person's physical and interpersonal environment. Assessment of changes in behaviour should include consideration of psychiatric disorders.

Social function

Accommodation

The suitability of the patient's existing accommodation setting to provide the best physical and psychological health outcomes should be assessed. This should include compatibility with other residents, the capacity of carers to support the patient's health and social needs and identification of any health and safety issues for that patient.

Consultation with patient's carer

Where the patient has a carer (paid or unpaid), it is important for the practitioner to consider issues that relate to the care provided by the carer, including whether they are able to meet the health related needs of the patient. The patient's carer is an important source of information about the efficacy and side effects of medication and the patient's symptomatology.

Involving the patient's carer

Where the patient has a carer (see note above), the medical practitioner may find it useful to consider having the carer present for the assessment or components of the assessment (subject to the patient's agreement). The patient's carer may be able to provide useful information on matters such as medication usage and compliance, continence and physical, psychological and social function. Where the provision of an assessment service involves consultation with a patient it should be read as including consultation with the patient's carer and/or representative where this is appropriate.

Involving Disability Professionals

It may be relevant to consult with disability professionals such as case managers who have responsibility for assessing and facilitating appropriate accommodation and disability support services, and psychologists who have responsibility for developing strategies to address challenging behaviour. If a patient needs but does not have such a professional involved, the practitioner should make appropriate referrals.

A.27.10 A record of the health assessment must be kept and a written report about the health assessment offered to the patient. The report must include recommendations identified during the health assessment. Where the patient has a formal carer or an informal or family carer, a copy of the report (or relevant extracts) should also be offered to the carer, with the agreement of the patient or his/her representative. Where appropriate the health assessment should be provided to the relevant disability professionals, with the agreement of the patient or where appropriate, their carer.

A.27.11 During the course of the 12 months following the assessment, the patient's GP is to review and adjust treatment of the patient as necessary, as part of normal medical care.

A.27.12 In circumstances where the patient's usual medical practitioner or practice does not undertake the health assessment, a copy of the health assessment report should be forwarded to that medical practitioner or practice (subject to the agreement of the patient or their representative).

A.27.13 The annual health assessment should not take the form of a health screening service, in particular the assessment should not include Category 5 (diagnostic imaging) services or Category 6 (pathology) services unless the health assessment detects issues that require clinically relevant diagnostic imaging or pathology services.

A.27.14 Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately or is appropriate, considering the patient's disability.

A.27.15 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.27.16 Where a component of the health assessment is conducted at consulting rooms and a component is conducted in the patient's home (including by a third party acting under the supervision of the practitioner) the latter item should be claimed.

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

M.2.10 Item 10996 can only be claimed by a medical practitioner (not including a specialist or consultant physician) where wound management (other than normal aftercare) is provided to a patient by a practice nurse on behalf of the medical practitioner.

M.2.11 Item 10996 can be claimed only once per patient visit, even if more than one wound is treated during the same patient visit.

M.2.12 A practice nurse means a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice.

M.2.13 The practice nurse must be appropriately qualified and trained to treat wounds.

M.2.14 The medical practitioner under whose supervision the treatment is provided retains responsibility for the health, safety and clinical outcomes of the patient.

M.2.15 The medical practitioner does not need to be present during the treatment of the wound. However, the medical practitioner must conduct an initial assessment of the patient (including under a distance supervision arrangement if the medical practitioner is not physically present) in order to give instruction in relation to the treatment of the wound.

Provision of monitoring and support for a person with a chronic disease by a practice nurse or registered Aboriginal Health Worker (item 10997)

M.2.43 Item 10997 may be claimed by a medical practitioner, including a general practitioner but not including a specialist or consultant physician, where a monitoring and support service for a person with a chronic disease care plan is provided by a practice nurse or registered Aboriginal Health Worker on behalf of that medical practitioner.

M.2.44 All GPs whether vocationally registered or not are eligible to claim this item. District Medical Officers (DMOs) employed by the Northern Territory Department of Health and Community Services are also eligible to claim this item. The term 'GP' is used in these notes as a generic reference to medical practitioners able to claim this item.

M.2.45 Item 10997 does not apply for services that are provided by any other Commonwealth or State funded services. However, where an exemption under subsection 19(2) of the Health Insurance Act 1973 has been granted to an Aboriginal Community Controlled Health Service or State/ Territory Government health clinic, item 10997 can be claimed for services provided by practice nurses or registered Aboriginal Health Workers salaried by or contracted to, the Service or health clinic. All requirements of the item must be met.

M.2.46 Item 10997 will assist patients who require access to ongoing care, routine treatment and ongoing monitoring and support between the more structured reviews of the care plan by the patient's usual GP.

M.2.47 Item 10997 may be used to provide:

- checks on clinical progress;
- monitoring medication compliance;
- self management advice, and;
- collection of information to support GP reviews of Care Plans.

The services provided by the practice nurse or Aboriginal Health Worker should be consistent with the scope of the GP Management Plan, Team Care Arrangements, or Multidisciplinary Care Plan.

M.2.48 Item 10997 may be claimed up to a maximum of 5 times per patient per calendar year.

M.2.49 Item 10997 may only be accessed by a patient with a GP Management Plan, Team Care Arrangements or Multidisciplinary Care Plan (items 721, 723, 725, 727, 729, 731).

M.2.50 Patients whose condition is unstable/deteriorating should be referred to their GP for further treatment.

M.2.51 A practice nurse means a registered or enrolled nurse or Nurse Practitioner who is employed by, or whose services are otherwise retained by a general practice.

M.2.52 An Aboriginal Health Worker means a person in the Northern Territory who is registered as an Aboriginal Health Worker under the Health Practitioners Act 2004 (NT), who is employed or retained by a general practice, or by a health service that has an exemption to claim Medicare benefits under sub-section 19(2) of the *Health Insurance Act 1973.*

M.2.53 In all cases, the GP under whose supervision the chronic disease monitoring and support is being provided retains responsibility for the health, safety and clinical outcomes of the patient. The GP must be satisfied that the practice nurse is appropriately qualified and trained to provide chronic disease support and monitoring. GPs are advised to consult their insurer concerning indemnity coverage for services performed on their behalf.

M.2.54 General practices where nurses or Aboriginal Health Workers provide chronic disease support and monitoring, should also have a written clinical risk management strategy covering issues like clinical roles, patient follow up and patient consent.

M.2.55 Continuing professional development is recommended for all nurses and Aboriginal Health Workers providing chronic disease monitoring and support.

M.2.56 Supervision by the GP at a distance is recognised as an acceptable form of supervision. This means that the claiming GP does not have to be physically present at the time the service is provided. However, the GP should be able to be contacted if required.

M.2.57 Where the GP and practice nurse/Aboriginal Health Worker are at the same location, the GP is not required to be present while the chronic disease monitoring and support is undertaken. It is up to the GP to decide whether they need to see the patient. Where the GP has a consultation with the patient, then the GP is entitled to claim a Medicare item for the time and complexity of their personal attendance on the patient. The time the patient spends receiving a service from the practice

nurse or Aboriginal Health Worker is itemised separately under item 10997 and should not be counted as part of the Medicare item claimed for time spent with the GP. Where the practice nurse or Aboriginal Health Worker provides another service (eg immunisation) on the same day, the GP is able to claim for both practice nurse/Aboriginal Health Worker items.

M.2.58 Item 10990 or 10991 (bulk billing incentives) can be claimed in conjunction with item 10997 provided the conditions of item 10990 or 10991 are satisfied (see explanatory note M.1).

T8.20 Gastrointestinal endoscopic procedures (Items 30473-30481, 30484-30487, 30490-30494, 30680-30694, 32084-32095, 32103, 32104 and 32106)

T8.20.1 The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

T8.20.2 Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;

(ii) 'Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting', Department Health and Ageing

(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

T8.20.3 Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

T8.20.4 These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

T8.24 Endoscopic Ultrasound +/- Fine Needle Aspiration (Item 30688-30694)

T8.24.1 The provider should make a record of the findings of the ultrasound imaging in the patient's notes for any service claimed against items 30688 to 30694.

T8.24.2 Endoscopic ultrasound is an appropriate investigation for patients in whom there is a strong clinical suspicion of pancreatic neoplasia with negative imaging (such as CT scanning). Scenarios include, but are not restricted to:

A middle aged or elderly patient with a first attack of otherwise unexplained (eg negative abdominal CT) first episode of acute pancreatitis; or

A patient with biochemical evidence of a neuroendocrine tumour.

The procedure is not claimable for periodic surveillance of patients at increased risk of pancreatic cancer, such as chronic pancreatitis. However, EUS would be appropriate for a patient with chronic pancreatitis in whom there was a clinical suspicion of pancreatic cancer (eg: a pancreatic mass occurring on a background of chronic pancreatitis).

T8.102 Breast prosthesis, removal and replacement of (items 45552 – 45555)

T8.102.1 It is generally expected that the replacement prosthesis will be the same size as the prosthesis that is removed. Medicare benefits are not payable for services under items 45552-45555 where the procedure is performed solely to increase breast size

DIL GROUP I2: COMPUTED TOMOGRAPHY (CT)
Upper abdomen and pelvis

Items 56501, 56507, 56541 and 56547 are not eligible for Medicare Benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography). CT Colonography is now covered by items 56552 and 56554.

Computed Tomography of the Colon

High Risk

Asymptomatic people fit into this category if they have:

- three or more first-degree or a combination of first-degree and second-degree relatives on the same side of the family diagnosed with bowel cancer (suspected hereditary non-polyposis colorectal cancer or NPCC), or
- two or more first-degree or second-degree relatives on the same side of the family diagnosed with bowel cancer, including any of the following high-risk features:
  - multiple bowel cancers in the one person
  - bowel cancer before the age of 50 years
- at least one relative with cancer of the endometrium, ovary, stomach, small bowel, ureter, biliary tract or brain;
- at least one first-degree relative with a large number of adenomas throughout the large bowel (suspected familial adenomatis polyposis or FAP), or
- somebody in the family in whom the presence of a high-risk mutation in the adenomatis polyposis coli (APC) gene or one of the mismatch repair (MMR) genes has been identified.

Source: NHMRC 2005 Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer - Category 3 — those at potentially high risk.

www.nhmrc.gov.au/publications/synopses/cp106/cp106syn.htm.

Incomplete Colonoscopy

For audit purposes, an incomplete colonoscopy is defined as one that is not completed for technical or medical reasons and must have been performed in the preceding 3 months.