Australian Government
Department of Health and Ageing

Medicare Benefits Schedule Book

Category 6

Operating from 01 November 2011

ISBN:
Online ISBN: 978-1-74241-575-8

Publications Approval Number: D0563

At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

The latest Medicare Benefits Schedule information is available from *MBS Online* at http://www.health.gov.au/mbsonline

TABLE OF CONTENTS

G.1.1. THE MEDICARE BENEFITS SCHEDULE - INTRODUCTION

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

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

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.

G.1.2. MEDICARE - AN OUTLINE

The Medicare Program ('Medicare') provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. **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.

G.1.3. MEDICARE BENEFITS AND BILLING PRACTICES

Key information on Medicare benefits and billing practices

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

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

Billing practices contrary to the Act

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

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

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

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

Potential consequence of improperly issuing an account

The potential consequences for improperly issuing an account are

(a). No Medicare benefits will be paid for the service;

(b). The medical practitioner who issued the account, or authorised its issue, may face charges under sections 128A or 128B of the *Health Insurance Act 1973*.

(c). Medicare benefits paid as a result of a false or misleading statement will be recoverable from the doctor under section 129AC of the *Health Insurance Act 1973*.

Providers should be aware that 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.

G.2.1. 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.

G.2.2. 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.

G.2.3. 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.

G.2.4. 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.

G.2.5. 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
NORTHERN TERRITORY As per South Australia	**AUSTRALIAN CAPITAL TERRITORY** Medicare Australia National Office 134 Reed Street North GREENWAY ACT 2901	

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.

G.3.1. 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.

G.3.2. 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"

G.3.3. 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.

G.3.4. 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 entitle 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.

G.4.1. 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.

G.5.1. 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.

G.5.2. EMERGENCY MEDICINE

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

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

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

G.6.1. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

For certain services provided by specialists and consultant physicians, the 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) sub-paragraphs (ii) and (iii) do not apply to
- a referral generated during an episode of hospital treatment, for a service provided or arranged by that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
- an emergency where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

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

Examination by Specialist Anaesthetists

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

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

Referrals by Dentists or Optometrists or Participating Midwives or Participating Nurse Practitioners
For Medicare benefit purposes, a referral may be made to

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

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

In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is <u>not</u> 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.

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 unreferred 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.

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

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

Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice 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 locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

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

G.7.1. BILLING PROCEDURES

Itemised Accounts
Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to claim 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 direct-bill 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 enrolees have entitlement limited to the date shown on the card and some enrolees, eg certain visitors to Australia, have restricted access to Medicare.

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 pay-group 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.

Direct-Bill Stationery (Forms DB6Ba & DB6Bb)

Medical practitioners wishing to direct-bill may obtain information on direct-bill 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 direct-billing (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.

G.8.1. 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 a 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 reduce 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

G.8.2. 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).

G.8.3. REFERRAL OF PROFESSIONAL ISSUES TO REGULATORY AND OTHER BODIES

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

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

G.8.4. COMPREHENSIVE MANAGEMENT FRAMEWORK FOR THE MBS

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

G.8.5. 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.

G.8.6. 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.

G.8.7. 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

G.9.1. 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 direct-billing form without the obligatory details having been entered on the form before the person signs, or who fails to cause a patient to be given a copy of the completed form.

G.10.1. 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 $73.70 (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. Patient's 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.

G.10.2. 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 x 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 x 80% = $20. As this is less than the EMSN benefit cap, the full $20 is paid.

G.11.1. 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.

G.11.2. 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)**".

G.12.1. 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 H*ealth 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 170-172). The requirement of "personal performance" is met whether or not assistance is provided, according to accepted medical standards:-

(a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11304, 11500, 11600, 11627, 11701, 11712, 11724, 11921, 12000, 12003;
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13020, 13025, 13200-13206, 13212-13221, 13703, 13706, 13709, 13750-13760, 13915-13948, 14050, 14053, 14218, 14221 and 14224);
(d) Item 15600 in Group T2 (Radiation Oncology);
(e) All Group T3 (Therapeutic Nuclear Medicine) items;
(f) All Group T4 (Obstetrics) items (except 16400 and 16514);
(g) All Group T6 (Anaesthetics) items;
(h) All Group T7 (Regional or Field Nerve Block) items;
(i) All Group T8 (Operations) items;
(j) All Group T9 (Assistance at Operations) items;
(k) All Group T10 (Relative Value Guide for Anaesthetics) items.

For the group psychotherapy and family group therapy services covered by Items 170, 171, 172, 342, 344 and 346, 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.

G.12.2. SERVICES RENDERED ON BEHALF OF MEDICAL PRACTITIONERS

Medical services in Categories 2 and 3 not included in the list above and Category 5 (Diagnostic Imaging) services continue to attract 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 self-employed medical or paramedical personnel, such as radiographers and audiologists, who either bill the patient or the practitioner requesting the service.

G.12.3. 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.

G.13.1. 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) Selective internal radiation therapy for any condition other than hepatic metastases that are secondary to colorectal cancer;
(l) Specific mass measurement of bone alkaline phosphatase;
(m) Transmyocardial laser revascularisation;
(n) Vertebral axial decompression therapy, for chronic back pain.
(o) Autologous Chondrocyte Implantation and Matrix-induced Autologous Chondrocyte Implantation.
(p) Vertebroplasty

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 for a person as a prerequisite of that person becoming eligible to foster a child or children;
- 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 of 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.

G.14.1. 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.

G.14.2. 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.

G.14.3. 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.

G.14.4. 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.

G.14.5. RESIDENTIAL AGED CARE FACILITY

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

G.15.1. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS

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

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

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

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

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

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

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

PATHOLOGY SERVICES

CATEGORY 6

SUMMARY OF CHANGES SINCE 1/07/2011

The 1/07/2011 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following words appearing above the item number

(a) new item	New
(b) amended description	Amend
(c) fee amended	Fee
(d) item number changed	Renum
(e) EMSN changed	EMSN

New items since 1/07/2011

73828 73829 73830 73831 73832 73833 73834 73835 73836 73837

P.1.1. PATHOLOGY SERVICES IN RELATION TO MEDICARE BENEFITS - OUTLINE OF ARRANGEMENTS

Basic Requirements

Determination of Necessity of Service
The treating practitioner must determine that the pathology service is necessary.

Request for Service
The service may only be provided:
(i) in response to a request from the treating practitioner, including a participating midwife or a participating nurse practitioner, or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or
(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

Services requested by participating midwives and participating nurse practitioners:
(i) A participating midwife can request the following services:
Items 65060, 65070, 65090 to 65099 (inclusive), 65114, 66500 to 66512 (inclusive), 66545, 66548, 66566, 66743, 66750, 66751, 69303 to 69317 (inclusive), 69324, 69384 to 69415 (inclusive), 73053 and 73529.

(ii) A participating nurse practitioner can request items in the range 65060 to 73529 (inclusive).

Provision of Service
The following conditions relate to provision of services:
(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;
(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;
(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;
(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and
(v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

Therapeutic Goods Act 1989
For any service listed in the MBS to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Approved Pathology Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of pathology services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

P.1.2. EXEMPTIONS TO BASIC REQUIREMENTS

Prescribed Pathology Services
A prescribed pathology service is a service included in Group P9 of the Pathology Services Table. Group P9 contains services which may be performed by a medical practitioner (items 73801 – 73811) or a participating nurse practitioner (items 73828 – 73837) in his or her own surgery on his or her own patients.

Additionally, benefit is payable only where the service is determined to be necessary by the medical practitioner or the participating nurse practitioner rendering the service, or is in response to a request by a member of a group of medical practitioners to which that medical practitioner belongs (see PO.2 for the definition of a "group of practitioners").

Services Where Request Not Required
A written request is not required for -
(i) a prescribed pathology service rendered by or on behalf of a medical practitioner or by a participating nurse practitioner upon his or her own patients;
(ii) a pathologist-determinable service. A pathologist-determinable service is a pathology service :
(a) that is specified rendered by or on behalf of an Approved Pathology Provider for a person who is a patient of that Approved Pathology Provider who has determined that the service is necessary; or
(b) that is specified in only one of immunohistochemistry items 72846, 72847 or 72848 or immunocytochemistry items 73059, 73060 or 73061 or electronmicroscopy items 72851 or 72852 and is considered necessary by the Approved Pathology Provider as a consequence of information resulting from a pathology service contained in tissue examination items 72813 – 72836, cytology items 73045 – 73051 or tissue examination items 72813 - 72836 respectively.
Please note: a written request is required for a service contained in items 72813 to 72836 and items 73045 to 73051.

(c) That is specified in one of the antigen detection items 69494, 69495 or 69496 is considered necessary by the specialist pathologist as a consequence of information provided by the requesting practitioner or by the nature or appearance of the specimen or as a consequence of information resulting from a pathology service contained in items 69303, 69306, 69312, 69318, 69321, 69345. Please note: a written request is required for a service contained in items 69303, 69306, 69312, 69318, 69321, 69345 or for a service contained in items 69494, 69495 or 69496.

(d) That is specified in item 73320, HLA-B27 typing by nucleic acid amplification, and is considered necessary by the specialist pathologist because the results of HLA-B27 typing described in item 71147 are unsatisfactory.

Further information on additional pathology tests not covered by a request is provided at PB.3.

P.1.3. CIRCUMSTANCES WHERE MEDICARE BENEFITS NOT ATTRACTED

Services Rendered by Disqualified Practitioner

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

Certain Pathology Tests Do Not Attract Medicare Benefits

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed.

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures;
- pathology services performed on stillborn babies or cadavers;
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services.

However, benefits will be paid for the following pathology tests:

- item 65060 - haemoglobin estimation;
- item 65090 - blood grouping ABO and Rh (D antigen);
- item 65096 - examination of serum for Rh and other blood group antibodies.

P.2.1. RESPONSIBILITIES OF TREATING/REQUESTING PRACTITIONERS

Form of Request

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners must be in accordance with the Medicare Australia approved form (see P.2.2). Written pathology requests from treating practitioners that are not on a form prepared and distributed by a pathologist do not need to be approved. However, all written requests for pathology services should contain the following particulars:

(i) the individual pathology services, or recognised groups of pathology tests to be rendered (see section PQ of these notes for the list of acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;
(ii) the date of request;
(iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;
(iv) the patient's name and address;
(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:
  (a) a private patient in a private hospital, or approved day hospital facility;
  (b) a private patient in a recognised hospital;
  (c) a public patient in a recognised hospital;
  (d) an outpatient of a recognised hospital;
(vi) details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Practitioner or an Approved Pathology Authority. If the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority. If the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

Offence Not to Confirm an Oral Request
A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

P.2.2. RESPONSIBILITIES OF APPROVED PATHOLOGY PRACTIONERS

Form of Request
There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable.

For the purposes of Medicare eligible services, the minimum information requirements for a pre –printed pathology request and combined pathology request/offer to assign are detailed within: *Health Insurance (Pathology Services) Regulations; Health Insurance Regulations 1975; Health Insurance Act 1973; and, Privacy Act.*

The following table presents the minimum details that pre printed pathology request forms and combined pathology request/offer to assign forms must contain for purposes of a subsequent Medicare claim:

Requesting Practitioner
a) surname and initials
b) address
c) provider number
d) date of request

Details of the person to whom the request is made
a) where the person is an APA/APP:- i) full name of APA/ Surname and initials of APP ii) a place of practice address iii) the letters APA or APP to be shown

Patient Details
a) name – surname, first name
b) address
c) date of birth
d) sex
e) Medicare card number
f) hospital status Two acceptable versions are as follows: State the patient's status at the time of the service or when the specimen was collected:

OR cross out the statements that do not apply

Was or will the patient be, at the time of the service or when the specimen is obtained:

(a) a private patient in a private hospital or approved day hospital facility
(b) a private patient in a recognised hospital
(c) a public patient in a recognised hospital
(d) an outpatient of a recognised hospital

Tests Requested

a) an area titled “Tests Requested”

Self Determined (SD)

A tick box is required for SD. This is used when the APP determines that pathologist-determinable tests are necessary. This tick box can be put in the Clinical Notes area.

Privacy Note
The wording of the note must be: "Privacy Note: The information provided will be used to assess any Medicare benefit payable for the services rendered and to facilitate the proper administration of government health programs, and may be used to update enrolment records. Its collection is authorised by provisions of the *Health Insurance Act 1973*. The information may be disclosed to the Department of Health and Ageing or to a person in the medical practice associated with this claim, or as authorised/required by law." The placement of the note is only necessary on the patient's copy and could be incorporated into the clinical notes area. Alternatively, the back of the patient copy could be used if that is more practicable

Combined Request/Assignment form only
Offer to Assign and Reference to Section 20A
An example of a Section 20A Offer to Assign is as follows: "Medicare Assignment (Section 20A of the Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner. **Patient signature _____ Date _____/_____/_____"**
Practitioners Use Only
A text box is also required for 'Practitioner's Use Only' this section is used where the patient is unable to sign and an appropriate person endorses on behalf of patient, eg. Practitioner's Use Only _____ **(Reason patient cannot sign)**

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides to practitioners (directly or indirectly) combined request/assignment forms which are not in accordance with the Medicare Australia approved form is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000.

Patient Copy

Assignment of benefits requires the patient to receive a copy of the request. The doctor must cause the particulars relating to the professional service (tests requested) 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.

Authority to lodge a Patient Claim electronically

Where an Approved Pathology Practitioner or Approved Pathology Authority renders a service and the patient has not assigned the benefit the Approved Pathology Practitioner or Approved Pathology Authority can lodge a claim electronically to Medicare Australia on behalf of the patient where consent is provided. This consent can be provided verbally.

Combined Online Patient Claiming Authority

Authority for APP/APA to submit an electronic patient claim on behalf of the claimant

An example of wording that could be used is:

'I authorise the approved pathology practitioner who will render the requested pathology services, and any further pathology services which the practitioner determines to be necessary, to submit my unpaid account to Medicare, so that Medicare can assess my claim and issue me a cheque made payable to the practitioner, for the Medicare benefit.'

Patient Signature_____ Date_____/_____/_____

_____

Verbal consent was provided by patient to submit unpaid account to Medicare. No signature available.

Request to Approved Pathology Authority

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

Holding, Retention, Recording and Production of Request Forms

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients. An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Ageing, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner or an Approved Pathology Authority is required to produce, on request from the Medicare Australia CEO, no later than the end of the day following the request from the CEO, a written request or written confirmation retained pursuant to the above paragraphs. An employee of Medicare Australia is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

Offences in Relation to Retaining and Producing Request Forms

The following offences are punishable upon conviction by a fine not exceeding $1000:

(i) an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;

(ii) an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an employee of Medicare Australia before the end of the day following the day of the Medicare Australia CEO's request.

Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

(i) where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner, and the document bearing the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

(ii) where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed, and when necessary, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account/receipt/assignment form:

(a) name and provider number of the original requesting practitioner; and

(b) date of original request;

(iii) under the item coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by Rule 6 entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (items 66800 and 66812) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in Rule 6 permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:

(i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;

(ii) photocopies of requests are not acceptable;

(iii) in the case of "designated pathology services" 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800,66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165 a patient episode initiation fee (PEI) is

payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

Offence Not To Confirm An Oral Request

An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding $1000, and the request is deemed never to have been made.

P.2.3. PATHOLOGY TESTS NOT COVERED BY REQUEST

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

P.3.1. DETAILS REQUIRED ON ACCOUNTS, RECEIPTS OR ASSIGNMENT FORMS

General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

P.3.2. APPROVED PATHOLOGY PRACTITIONERS

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

(i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;
(ii) the name of the person to whom the service was rendered;
(iii) the date on which the service was rendered;
(iv) the name of the requesting practitioner; or in the case of a referred test, the name of the original requesting practitioner;
(v) the date on which the request was made; or in the case of a referred test, the date on which the original request was made;
(vi) the requesting practitioner's provider number;
(vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered. Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at PQ.4 are acceptable alternatives (see PQ.1);
(viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and
(ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be identical to those of the original requesting practitioner including the date of request.

P.3.3. PRESCRIBED PATHOLOGY SERVICES

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from

other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

P.4.1. INBUILT MULTIPLE SERVICES RULE

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

P.4.2. EXEMPTIONS

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 6 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. "…. each test to a maximum of 4 tests in a 12 month period".

P.5.1. EPISODE CONE

Description of Rule 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in PO.5 of these notes.

P.5.2. EXEMPTIONS

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items identified in Rule 18.(1)(d) and (e).

P.6.1. BULK BILLING INCENTIVES FOR EPISODES CONSISTING OF A P10 SERVICE

The Fees for items in Group P13 are additional payments for bulk billing a patient episode consisting of a pathology service to which a Group P10 item (Pathology Episode Initiation fee) applies.

P.6.2. PATIENT EPISODE INITIATION FEES (PEIS)

Items in Groups P10 of the Pathology Services Table are only applicable to services performed:

(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and

(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a privately referred out-patient of a recognised hospital.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 14.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 14.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

- a tissue pathology specimen and any other non-tissue pathology specimen; or
- a cytopathology specimen and any other non-cytopathology specimen.

Rule 14.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation benefits are two-tiered. Higher benefits are paid for the collection of specimens from patients who are not private inpatients or private outpatients of a recognised hospital where the specimens are tested in a private laboratory.

A lower and uniform PEI benefit is paid where patients are private patients associated with a recognised hospital and the specimens are tested in a private laboratory or where the testing is performed by a prescribed laboratory on specimen collected from a patient eligible to claim Medicare benefits.

P.6.3. Patient Episode Initiation Fees for Certain Tissue Pathology and Cytology Items

Tissue Pathology items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 and Cytology items 73053, 73055 and 73057 will be subject to a different patient episode initiation fee structure - items 73922 to 73939 refer.

P.6.4. Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PF.2 and PF.3:

(i) laboratories operated by the Australian Government (these include health laboratories operated by the Australian Government Department of Health and Ageing as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

(ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);

(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and

(iv) laboratories operated by Australian tertiary education institutions eg Universities.

P.7.1. Assignment of Medicare Benefits - Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 7 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

P.7.2. Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

P.8.1. Accredited Pathology Laboratories - Need for Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

P.8.2. APPLYING FOR ACCREDITATION

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, Medicare Australia, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category GX labs
- $2000 for Category GY labs
- $1500 for Category B labs
- $ 750 for Category M & S labs.

It is necessary for an application for inspection be made to the National Association of Testing Authorities (NATA) NATA is the independent body chosen to act on the Australian Government's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

Details of laboratory categories and associated supervisory requirements can be found on the Department's internet site (www.health.gov.au/pathology).

P.8.3. EFFECTIVE PERIOD OF ACCREDITATION

Accreditation takes effect from the date of approval by the Minister for Health and Ageing. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

P.8.4. ASSESSMENT OF APPLICATIONS FOR ACCREDITATION

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 4017 or email npaac@health.gov.au .

P.8.5. REFUSAL OF ACCREDITATION AND RIGHT OF REVIEW

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

P.8.6. NATIONAL PATHOLOGY ACCREDITATION ADVISORY COUNCIL (NPAAC)

NPAAC was established in 1979. Its functions are to develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Australian Government's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 4017 or email npaac@health.gov.au.

P.8.7. CHANGE OF ADDRESS/LOCATION

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Ageing. Paragraph PH.2 sets out the method for applying for accreditation.

P.8.8. CHANGE OF OWNERSHIP OF A LABORATORY

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Ageing must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

P.8.9. APPROVED COLLECTION CENTRES (ACC)

New arrangements for specimen collection centres commenced on 1 December 2001 and replaced the Licensed Collection Centre (LCC) Scheme.

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be approved. The exception to this rule is collection centres on the premises of recognised hospitals (recognised hospital in this context means the same as "recognized hospital" in Part 1 Section 3 of the Health Insurance Act 1973) as they do not need approval.

In order for a collection centre to be approved, a public or private Approved Pathology Authority must submit a completed application form to Medicare Australia including details of the type of application (renewal, new or cancellation of collection centre), the location of the premises, the owner, and any leasing arrangements.

Application forms can be accessed by going to Medicare Australia website www.medicareaustralia.gov.au. Completed application forms and any enquiries should be forwarded to Pathology Registration, PO Box 9822 MELBOURNE VIC 3001.

P.9.1. APPROVED PATHOLOGY PRACTITIONERS

Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

P.9.2. APPLYING FOR ACCEPTANCE OF THE APPROVED PATHOLOGY PRACTITIONER UNDERTAKING

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration Co ordinator, Medicare Australia, PO Box 9822 (in your capital city).

An application form, undertaking and associated literature can be obtained from the Pathology Registration Co-ordinator.

Payment of Acceptance Fee

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500 should be despatched to the Pathology Registration Co-ordinator. Applicants are required to pay this fee within 14 days of the notice being given (ie. the day the notice is sent).

As there is no discretion under the Health Insurance Act 1973 to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

Reminder Process

In administering the Approved Pathology Authority and Approved Pathology Practitioner arrangements, Medicare Australia provides reminders to ensure that:

(i) applicants whose undertaking are about to expire are aware of the consequences of late lodgement; and

(ii) where the 14 day period for payment of fees is about to expire and the fees have not been paid, that applicants are aware of the consequences of failure to pay on time.

P.9.3. UNDERTAKINGS

Consideration of Undertakings

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking
The following applies:
(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;
(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;
(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by Medicare Australia until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and
(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

P.9.4. OBLIGATIONS AND RESPONSIBILITIES OF APPROVED PATHOLOGY PRACTITIONERS

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

P.10.1. APPROVED PATHOLOGY AUTHORITIES

Introduction
A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

P.10.2. APPLYING FOR ACCEPTANCE OF AN APPROVED PATHOLOGY AUTHORITY UNDERTAKING

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:
(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and
(ii) a signed Approved Pathology Authority Undertaking.

to the Manager Pathology Section, Health Insurance Section, PO Box 1001, Tuggeranong ACT 2901. Application forms, undertakings and associated literature can be obtained from the Pathology Registration Co-ordinator.

The application and the undertaking should be completed by the proprietor of the laboratory/ies and where the proprietor is not a natural person (e.g. company or partnership), an authorised representative/s should complete the forms. This proprietor can be:
(i) a natural person;
(ii) partners (natural persons and/or companies) in a partnership;
(iii) a body corporate (i.e. a company); or
(iv) a government authority (e.g. a public hospital).

Payment of Acceptance Fee
On receipt of advice that the Minister has accepted an undertaking, a cheque for $1,500 should be dispatched within 14 days or the undertaking will be cancelled and the whole process begun again with a consequent gap in the payment of benefits.

P.10.3. UNDERTAKINGS

Consideration of Undertakings
The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

Refusal of Undertaking and Rights of Review
Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

Effective Period of Undertaking
The following applies:
(i) Date of Effect the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;
(ii) Period of Effect in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;
(iii) Renewals when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by Medicare Australia until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and
(iv) Cessation of Undertaking the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

P.10.4. OBLIGATIONS AND RESPONSIBILITIES OF APPROVED PATHOLOGY AUTHORITIES

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

P.11.1. BREACHES OF UNDERTAKINGS

Notice Required
Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

P.11.2. DECISIONS BY MINISTER

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

P.11.3. APPEALS

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Public Service Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

P.12.1. INITIATION OF EXCESSIVE PATHOLOGY SERVICES

Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

P.12.2. CLASSES OF PERSONS

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

P.12.3. DECISIONS BY MINISTER FOR HEALTH AND AGEING

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

P.12.4. APPEALS

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

P.13.1. PERSONAL SUPERVISION

Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

P.13.2. EXTRACT FROM UNDERTAKING

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

Part 2 – Personal supervision

2.1 I acknowledge that it is my obligation, subject to Parts 2.2 and 2.4, personally to supervise any person who renders any service on my behalf and I undertake to accept personal responsibility for the rendering of that service under the following conditions of personal supervision:

(i) Subject to the following conditions, I will usually be physically available in the laboratory while services are being provided at the laboratory;

(ii) I may, subject to paragraph (vi) below, be physically absent from the laboratory while services are being rendered outside its normal hours of operation but in that event I will leave with the person rendering the service particulars of the manner in which I may be contacted while the service is being rendered and I must be able to personally attend at the laboratory while the service is being rendered or formally designate another APP present while I am absent;

(iii) I may, subject to paragraph (vi) below, be absent from the laboratory for brief periods due to illness or other personal necessity, or to take part in activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory;
(iv) I will personally keep a written log of my absences from the laboratory that extend beyond one workday in respect of that laboratory and will retain that log in the laboratory for 18 months from date of last entry;
(v) If I am to be absent from the laboratory for more than 7 consecutive workdays, I will arrange for another APP to personally supervise the rendering of services in the laboratory. That arrangement shall be recorded in writing and retained in the laboratory for 18 months from date of last entry. Until such person is appointed, and his or her appointment is recorded in writing, I will remain personally responsible to comply with this undertaking;
(vi) If a service is being rendered on my behalf by a person who is not:
(a) a medical practitioner;
(b) a scientist; or
(c) a person having special qualifications or skills relevant to the service being rendered;
and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service;

(vii) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:
(a) all persons who render services are adequately trained;
(b) all services which are to be rendered in the laboratory are allocated to persons employed by the APA and, these persons shall have appropriate qualifications and experience to render the services;
(c) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;
(d) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and
(e) results of services and tests rendered are accurately recorded and sent to the treating practitioner and, where applicable, a referring practitioner;

(viii) If I perform, or there is performed on my behalf, a service which consists of the analysis of a specimen which I know, or have reason to believe, has been taken other than in accordance with the provisions of section 16A(5AA) of the Act I will endorse, or cause to be endorsed, on the assignment form or the account for that service, as the case may be, particulars of the circumstances in which I believe, or have reason to believe, the specimen was taken.

2.2 Where services are to be rendered on my behalf in a Category B laboratory as defined in the Health Insurance (Accredited Pathology Laboratories – Approval) Principles 2002, I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of an appropriate person as required by those Principles as in force from time to time.
2.3 I acknowledge to the best of my ability that any act or omission by a person, when acting with my authority, whether express or implied, that would, had it been done by me, have resulted in a breach of this undertaking, constitutes a breach of this undertaking by me.
2.4 Parts 2.1(i) to 2.1(vi) and 2.2 of this undertaking do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in Schedule 3.

P.13.3. NOTES ON THE ABOVE

Part 2 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

P.14.1. CHANGES TO THE PATHOLOGY SERVICES TABLE

Health Insurance Regulations
The *Health Insurance Act 1973* allows the Minister for Health and Ageing to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established the Pathology Services Table Committee (PSTC) to assist in determining changes to the Table (except new medical services and technologies - see below). Any person or organisation seeking to make a submission to this Committee can contact the PSTC Secretariat on (02) 6289 4080 or e-mail pstc.secretariat@health.gov.au and/or write to: Secretary, PSTC, MDP 107, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601.

Pathology submissions relating to new medical services and technologies should be forwarded to the Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining

to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email msac.secretariat@health.gov.au and/or write to: MSAC Secretariat, Australian Government, Department of Health and Ageing, MDP 106, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website – www.msac.gov.au

P.15.1. EXPLANATORY NOTES - DEFINITIONS

Excessive Pathology Service
This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

P.15.2. GROUP OF PRACTITIONERS

This means:
(i) a practitioner conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or
(ii) two or more practitioners conducting a medical practice or a dental practice, or a participating nurse practitioner practice, or a participating midwife practice as partners; or
(iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

P.15.3. INITIATE

In relation to a pathology service this means to request the provision of pathology services for a patient.

P.15.4. PATIENT EPISODE

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PD.2 for further information on exemptions.

Rule 14.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

P.15.5. EPISODE CONE

The episode cone is an arrangement, described in Rule 18, which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Rule 18 provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:
(i) all the items in Groups P10, P11, P12 and P13;
(ii) Pap smear testing (items 73053 and 73055);

(iii) all the itemsdetailed at Rule 18 (e) (items 65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318);
(iv) supplementary test for Hepatitis B and Hepatitis C (item 69484); and
(v) the carbon-labelled urea breath test to confirm or monitor Helicobacter pylori (item 66900).

P.15.6. PERSONAL SUPERVISION

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See PM.1 to PM.3 for a full description of the responsibilities involved in personal supervision.

P.15.7. PRESCRIBED PATHOLOGY SERVICE

These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

P.15.8. PROPRIETOR OF A LABORATORY

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:
(i) the laboratory premises, whether or not the holder of an estate or interest in the premises;
(ii) the use of equipment used in the laboratory; and
(iii) the employment of staff in the laboratory.

P.15.9. SPECIALIST PATHOLOGIST

This means a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist in pathology (see 5.1 of the "General Explanatory Notes" in Section 1 of this book). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

P.15.10. DESIGNATED PATHOLOGY SERVICE

This means a pathology service specified in items 65150, 65175 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

P.16.1. INTERPRETATION OF THE SCHEDULE - ITEMS REFERRING TO 'THE DETECTION OF'

Items that contain the term ‘detection of’ should be taken to mean ‘testing for the presence of’.

P.16.2. BLOOD GROUPING - (ITEM 65096)

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is 65096.

P.16.3. GLYCOSYLATED HAEMOGLOBIN - (ITEM 66551)

The requirement of "established diabetes" in this item may be satisfied by:
(a) a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held in the database of the Approved Pathology Authority; or
(b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pathology Authority; or
(c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

P.16.4. IRON STUDIES - (ITEM 66596)

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is 66596.

P.16.5. FAECAL OCCULT BLOOD - (ITEMS 66764 TO 66770)

P.16.6. ANTIBIOTICS/ANTIMICROBIAL CHEMOTHERAPEUTIC AGENTS

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item 66800 or 66812 - 'quantitation of a drug being used therapeutically'.

P.16.7. HUMAN IMMUNODEFICIENCY VIRUS (HIV) DIAGNOSTIC TESTS - (INCLUDED IN ITEMS 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413 AND 69415)

Prior to ordering an HIV diagnostics tests (included in items 69384, 69387, 69390, 69393, 69396, 69405, 69408, 69411, 69413, 69415) the ordering practitioner should ensure that the patient has given informed consent. Appropriate discussion should be provided to the patient. Further discussion may be necessary upon receipt of the test results.

P.16.8. HEPATITIS - (ITEM 69481)

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".

P.16.9. EOSINOPHIL CATIONIC PROTEIN - (ITEM 71095)

Item 71095 applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

P.16.10. TISSUE PATHOLOGY AND CYTOLOGY - (ITEMS 72813 TO 73061)

When services described in Group P5 need to be performed upon material which is submitted for cytology items listed in Group P6 only the fee for the P6 item can be claimed.

P.16.11. CERVICAL AND VAGINAL CYTOLOGY - (ITEMS 73053 TO 73057)

Item 73053 applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. This item also applies to smears repeated due to an unsatisfactory routine smear, or if there is inadequate information provided to use item 73055.

Cytological examinations carried out under item 73053 should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:

(i) an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later; and

(ii) cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The *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.

P.16.12. FRAGILE X (A) TESTS - (ITEMS 73300 AND 73305)

Prior to ordering these tests (73300 and 73305) the ordering practitioner should ensure the patient has given informed consent. Appropriate genetic counselling should be provided to the patient either by the treating practitioner, a genetic counselling service or by a clinical geneticist on referral. Further counselling may be necessary upon receipt of the test results.

P.16.13. ADDITIONAL BULK BILLING PAYMENT FOR PATHOLOGY SERVICES - (ITEM 74990 AND 74991)

Item 74990 operates in the same way as item 10990 and item 74991 operates in the same way as item 10991, apart from the following differences:

- Item 74990 and 74991 can only be used in conjunction with items in the Pathology Services Table of the MBS;
- Item 74990 and 74991 applies to unreferred pathology services performed by a medical practitioner which are included in Group P9 of the Pathology Services Table, and unreferred pathology services provided by category M laboratories;
- Item 74990 and item 74991 applies to pathology services self determined by general practitioners and specialists with dual qualifications acting in their capacity as general practitioners;
- Specialists and consultant physicians who provide pathology services are not able to claim item 74990 or item 74991 unless, for the purposes of the Health Insurance Act, the medical practitioner is also a general practitioner and the service provided by the medical practitioner has not been referred to that practitioner by another medical practitioner or person with referring rights.

Rules 3 and 18 of the *Health Insurance (Pathology Services Table) Regulations 2003* have been amended to exclude item 74990 and 74991 from the Multiple Services Rule and the Coning Rule.

Item 74991 can only be used where the service is provided at, or from, a practice location in a regional, rural or remote area (RRMA 3 to 7 under the Rural Remote Metropolitan Areas classification system), or in all of Tasmania.

P.16.14. TRANSFER OF EXISTING ITEMS FROM GROUP P1 (HAEMATOLOGY) TO GROUP P7 GENETICS EFFECTIVE 1 MAY 2006.

P16.14 has been created to note the transfer of existing items from Group P1 (Haematology) items 65168, 65174, 65200 and item 66794 from Group P2 (Chemistry) to Group P7 (Genetics) as items 73308, 73311, 73314, 73317 and the introduction of the new item in Group P7 (Genetics) item 73320 HLA-B27 typing by nucleic acid amplification (NAA) which was effective as of 1 May 2006.

P.17.1. ABBREVIATIONS, GROUPS OF TESTS

As stated at P3.2 of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and
- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

P.17.2. TESTS NOT LISTED

Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained at PN.1 of the Outline, changes to the Pathology Services Table can only be made by the Minister for Health and Ageing.

P.17.3. AUDIT OF CLAIMS

Medicare Australia is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the Health Insurance Act 1973.

P.17.4. GROUPS OF TESTS

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item. These groups exclude abbreviations such as MBA and TORCH.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes or cardiac markers	Creatine kinase isoemzymes, Myoglobin, Troponin	CE / CM	66518, 66519
Coagulation studies	Full blood count, Prothrombin time, Activated partial thromboplastin time and two or more of the following tests – Fibrinogen, Thrombin, Clotting time, Fibrinogen degradation products, Fibrin monomer, D-dimer factor XIII screening tests	COAG	65129, 65070
Electrolytes	Sodium (NA), Potassium (K), Chloride (CL) and Bicarbonate (HCO3)	E	66509
Full Blood Examination	Erythrocyte count, Haematocrit, Haemoglobin, Platelet count, Red cell count, Leucocyte count, Manual or instrument generated differential, Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and Triglycerides (TRIG)	FATS	66503
Liver function tests	Alkaline phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Albumin (ALB), Bilirubin (BIL), Gamma glutamyl transpeptidase (GGT), Lactate dehydrogenase (LDH), and Protein (PROT)	LFT	66512
Syphilis serology	Rapid plasma regain test (RPR), or Venereal disease research laboratory test (VDRL), and Treponema pallidum haemagglutin test (TPHA), or Fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, Electrolytes, Creatinine	Urea, Electrolytes, Creatinine	U&E	66512

P.18.1. COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

Only one of these histopathology examination items (72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830, 72836 and 72838) can be claimed in a patient episode.

The remaining items (72844, 72846, 72847, 72848, 72851, 72852, 72855, 72856 and 72857) are add-on items, covering enzyme histochemistry and immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item.

The list of complexity levels by type of specimen are contained at the back of this Section.

P.19.1. PATHOLOGY SERVICES TABLE

Rules for the Interpretation of the Pathology Services Table

Please note that in the Health Insurance (Pathology Services Table) Regulations 2010 (effective 1 November 2010) rules and sub-rules are referred to as clauses and sub-clauses. In addition in the Regulations a rule that refers to specific items

within a pathology group, for example Group P1 Haemotology, is listed directly above the Schedule of Services for that group. A table cross referencing the following rules with the clauses in the Regulations is at the end of this section.

1. (1) In this table

patient episode means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:

(i) on the same day; or

(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or

(iv) are described in a single item or in more than 1 item; or

(v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or

(vi) are rendered on the same or different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

receiving APP means an approved pathology practitioner in an approved pathology authority who performs one or more pathology services in respect of a single patient episode following receipt of a request for those services from a referring APP.

recognised pathologist means a medical practitioner recognised as a specialist in pathology by a determination under section 3D, 3DB or 3E of the Act.

referring APP means an approved pathology practitioner in an approved pathology authority who:

(i) has been requested to render 1 or more pathology services, all of which are requested in a single patient episode; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the pathology services; and

(iii) requests an approved pathology practitioner (the ***receiving APP***) in another approved pathology authority to render the pathology service or services that the referring APP is unable to render; and

(iv) renders each pathology service (if any) included in that patient episode, other than the pathology service or services in respect of which the request mentioned in subparagraph (iii) is made.

serial examinations means a series of examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

***the* Act** means the *Health Insurance Act 1973.*

1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.

1. (3) A reference in this table by number to an item that is not included in this table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.

1. (4) A reference to a **Group** in the table includes every item in the Group and a reference to a **Subgroup** in the table includes every item in the Subgroup.

Precedence of items

2. (1) If a service is described:

(a) in an item in general terms; and

(b) in another item in specific terms;

only the item that describes the service in specific terms applies to the service.

2. (2) Subject to subrule (3), if:

(a) subrule (1) does not apply; and

(b) a service is described in 2 or more items;

only the item that provides the lower or lowest fee for the service applies to the service.

2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

Application of item 74990 and 74991

2. (4) Despite subrules (1), (2) and (3):

(a) if the pathology service described in item 74991 is provided to a person, either that item or item 74990, but not both those items, applies to the service; and

(b) if item 74990 or 74991 applies to a pathology service, the fee specified in that item applies in addition to the fee specified in any other item in the table that applies to the service.

2. (5) For items 74990 and 74991:

bulk-billed, in relation to a pathology service, means:

(a) a medicare benefit is payable to a person in respect of the service; and

(b) under an agreement entered into under section 20A of the Act:

(i) the person assigns to the practitioner by whom, or on whose behalf, the service is provided, his or her right to the payment of the medicare benefit; and

(ii) the practitioner accepts the assignment in full payment of his or her fee for the service provided.

Commonwealth concession card holder means a person who is a concessional beneficiary within the meaning given by subsection 84 (1) of the *National Health Act 1953*.

unreferred service means a pathology service that:

(a) is provided to a person by, or on behalf of, a medical practitioner, being a medical practitioner who is not a consultant physician, or specialist, in any speciality (other than a medical practitioner who is, for the purposes of the Act, both a general practitioner and a consultant physician, or specialist, in a particular speciality); and

(b) has not been referred to the medical practitioner by another medical practitioner or person with referring rights.

2. (6) For item 74991:

ASGC means the document titled Australian Standard Geographical Classification (ASGC) 2002, published by the Australian Bureau of Statistics, as in force on 1 July 2002.

practice location, in relation to the provision of a pathology service, means the place of practice in respect of which the practitioner by whom, or on whose behalf, the service is provided, has been allocated a provider number by the Commission**.**

Regional, rural or remote area means an area classified as RRMAs 3-7 under the Rural, Remote and Metropolitan Areas Classification.

Rural, Remote and Metropolitan Areas Classification has the meaning given by subrule 3 (1) of Part 2 of Schedule 1 to the general medical services table**.**

SLA means a Statistical Local Area specified in the ASGC.

SSD mean a Statistical Subdivision specified in the ASGC.

Circumstances in which services rendered following 2 requests to be taken to have been rendered following 1 request

3. (1) In subrule 3(2), ***service*** includes assay, estimation and test.

3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and

(ab) that item is not item 74990 or 74991; and

(b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item 65060, 65070, 65120, 65123, 65126, 65129, 65150, 65153, 65156, 66500, 66503, 66506, 66509, 66512, 66584 or 66800, if:

(a) the service is rendered in relation to one or more specimens taken on each of not more than 6 separate occasions in a period of 24 hours; and

(b) the service is rendered to an inpatient in a hospital; and

(c) each service must be rendered as soon as possible after collection and after authorization of the result of the previous specimen; and

(d) the account for the service is endorsed 'Rule 3 Exemption'.

4. (2) Rule 3 does not apply to any of the following pathology services:

(a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;

(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;

(c) a service described in item 65070 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service described in item 65070 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulphasalazine or penicillamine therapy of a patient;

(e) a service described in item 66500 - 66512 in relation to methotrexate or leflunomide therapy of a patient;

(f) quantitative estimation of urea, creatinine and electrolytes in relation to:

(i) cis-platinum or cyclosporin therapy of a patient; or

(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;

(g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;

(h) quantitative estimation of calcium, phosphate, magnesium, urea, creatinine and electrolytes in cancer patients receiving bisphosphonate infusions.

if:

(i) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and

(ii) the tests are performed within 6 months of the request; and

(iii) the account for the service is endorsed "Rule 3 Exemption".

4. (3) Rule 3 does not apply to a pathology service described in items 65109 or 65110 if:

(a) The service is rendered on not more than 5 separate occasions in the case of item 65109 and 2 separate occasions in the case of item 65110 in a period of 24 hours; and

(b) The service is rendered in response to a written request separated in time from the previous request; and

(c) The account for the service is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

5. (1) For an item in Group P1 (Haematology):

(a) if pathology services of a kind referred to in item 65090 or 65093 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and

(b) if:

(i) tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65099, 65102, 65105 and 65108) are carried out on the stored material; the later tests and the earlier tests are taken to be part of one patient episode.

5. (2) Benefits for items 65102 and 65108 are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.

5.(3) For items 65099 and 65102:

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

Certain items not to apply to a service referred by one pathology practitioner to another

6. (1) In this rule:

designated pathology service means a pathology service in respect of tests relating to a single patient episode that are tests of the kind described in item 65150, 65175, 66650, 66695, 66711, 66722, 66785, 66800, 66812, 66819, 66825, 69384, 69494, 71089, 71153 or 71165.

6. (2) This rule applies in respect of a designated pathology service where:

(a) an approved pathology practitioner ***(practitioner A)*** in an approved pathology authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more of the tests included in the service; and

(iii) requests an approved pathology practitioner ***(practitioner B)*** in another approved pathology authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test (if any) included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made; and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 65156, 65179, 66653, 66712, 66734, 66788, 66806, 66815, 66822, 66828, 69496, 71093, 71159 or 71168.

6. (3) If this rule applies in respect of a designated pathology service:

(a) item 65150, 65153, 65175, 65176, 65177, 65178, 66650, 66695, 66698, 66701, 66704, 66707, 66711, 66722, 66725, 66728, 66731, 66785, 66800, 66803, 66812, 66819, 66825, 69384, 69387, 69390, 69393, 69396, 69494, 69495, 71089, 71091, 71153, 71155, 71157, 71165, 71166 or 71167 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) and:

(i) practitioner A has rendered one or more of the tests that the service comprises - subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each test that the service comprises; or

(ii) practitioner A has not rendered any of the tests that the service comprises -

(A) the amount specified in item 65157, 65180, 66651, 66696, 66714, 66723, 66789, 66804, 66816, 66820, 66826, 69400, 69497, 71090, 71154 or 71169 (as the case requires) shall be taken to be the fee for the first test that the service comprises; and

(B) subject to subrule (4), the amount specified in item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 (as the case requires) shall be taken to be the fee for each subsequent test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item 65158, 65181, 66652, 66697, 66715, 66724, 66790, 66805, 66817, 66821, 66827, 69401, 69498, 71092, 71156 or 71170 applies is:

(a) for item 66652, 66715, 66790, 66817, 66821 or 66827:
2 – X; and

(b) for item 65158, 66805, 69498 or 71092:
3 – X; and

(c) for item 71156 or 71170:
4 – X; and

(d) for item 65181 or 66724:
5 – X; and

where X is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second mentioned approved pathology practitioner in subrule (2).

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one approved pathology

practitioner in respect of a single patient episode.

Creatinine ratios – Group P2 (chemical)

8. A pathology service mentioned in an item (except item 66500) in Group P2 (chemical) that:
(a) involves the measurement of a substance in urine; and
(b) requires calculation of a substance/creatinine ratio;
is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item 66719:
abnormal level of TSH means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

9. (2) Except where paragraph (a) of item 66719 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

9. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66719; or
(b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group P3 (Microbiology):
(a) ***serial examinations or cultures*** means a series of examinations or cultures requested on 1 occasion whether or not:
(i) the materials are received on different days by the approved pathology practitioner; or
(ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and

(b) if:
(i) tests are carried out in relation to a patient episode; and
(ii) specimen material from the patient episode is stored; and
(iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis serology

11. A medicare benefit is not payable in respect of more than one of items 69475, 69478 and 69481 in a patient episode.

Tests in Group P4 (Immunology) relating to antibodies

12. For items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:
(a) tests are carried out in relation to a patient episode; and
(b) specimen material from the patient episode is stored; and
(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;
the later tests and the earlier tests are taken to be part of one patient episode.

Tests on biopsy material - Group P5 (Tissue pathology) and Group P6 (Cytology)

13. (1) For items in Group P5 (Tissue pathology):
(a) ***biopsy material*** means all tissue received by the Approved Pathology Practitioner:
(i) from a medical procedure or group of medical procedures performed on a patient at the same time; or
(ii) after being expelled spontaneously from a patient.
(b) ***cytology*** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure

to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and

(c) ***separately identified specimen*** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

13. (2) For Groups P5 and P6 of the pathology services table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 are performed in a single patient episode, only the fee for the item performed having the highest specified fee is applicable to the services.

13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

13.(6) In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72827, 72828, 72830, 72836 and 72838 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 5 of this Table.

13.(7) If more than 1 of the services mentioned in items 72846, 72847, 72848; 72849 and 72850 or 73059, 73060, 73061, 73064 and 73065 are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest scheduled fee.

13.(8) If more than 1 of the services mentioned in items 73049, 73051, 73062, 73063, 73066 and 73067 are performed in a single patient episode, only the fee for the item performed having the higher or highest specified fee applies to the services.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

14. (1) For this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred):

approved collection centre has the same meaning as in Part IIA of the Act.

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:
(a) disadvantaged children; or
(b) juvenile offenders; or
(c) aged persons; or
(d) chronically ill psychiatric patients; or
(e) homeless persons; or
(f) unemployed persons; or
(g) persons suffering from alcoholism; or
(h) persons addicted to drugs; or
(i) physically or mentally handicapped persons;
but does not include:
(j) a hospital; or
(k) a residential aged care home; or
(l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

prescribed laboratory means a laboratory operated by:
(a) the Australian Government; or
(b) an authority of the Commonwealth; or
(c) a State or internal Territory; or
(d) an authority of a State or internal Territory; or
(e) an Australian tertiary education institution.

specimen collection centre has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group P10 is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(a) the service is rendered upon a request made in the course of a service provided to a public patient in a recognised hospital or when attending an outpatient service of a recognised hospital.

14. (3) An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A (7) of the Act applies.

14. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least 1 item in Groups P1 to P8 also applies to the service.

14. (5) Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in the Group applies to the patient episode.

14. (6) An item in Group P11 applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

14. (7) If, in respect of the same patient episode:
(a) services referred to in 1 or more items in Group P5 and 1 or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or
(b) services referred to in 1 or more items in Group P6 and 1 or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another approved pathology practitioner in the laboratory of another approved pathology authority;
the fee specified in the applicable item in Group P10 is payable to both approved pathology practitioners.

14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:
(a) in accordance with more than 1 request; and
(b) in or by a single approved pathology authority;
the fee specified in the applicable item in Group P10 applies once only to the services unless an exemption listed in Rule 4 applies or an exemption has been granted under Rule 3 “S4B(3)”.

14. (9) The amount specified in item 73940 is payable only once in respect of a single patient episode.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

15. If item 73940 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item 73940 in respect of the patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

16. (1) An item in Group P11 does not apply to a referral if:

(a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and
(b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.

16. (2) An approved pathology authority is ***related to*** another approved pathology authority for subrule (1) if:
(a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or
(b) either of the approved pathology authorities is employed (including employed under contract) by the other; or
(c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Act; or
(d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities; or

(e) both approved pathology authorities are operated by the Commonwealth or an authority of the Commonwealth; or
(f) both approved pathology authorities are operated by the same State or internal Territory or an authority of the same State or internal Territory.

16. (3) An item in Group P11 does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): 65060, 65070, 65120, 66500, 66503, 66506, 66509, 66512, 66536, 66596, 69300, 69303, 69333 or 73527.

Abbreviations

17. (1) The abbreviations in Part 4 of this table may be used to identify particular pathology services or groups of pathology services.

17. (2) The names of services or drugs not listed in Part 4 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) **In this rule:**

general practitioner means a medical practitioner who:
(a) is not a consultant physician in any specialty; and
(b) is not a specialist in any specialty.

set of pathology services means a group of pathology services:
(a) that consists of services that are described in at least 4 different items; and
(b) all of which are requested in a single patient episode; and
(c) each of which relates to a patient who is not an admitted patient of a hospital; and
(d) excludes services referred to in an item in Group P10, Group P11, Group P12 or Group P13, items 66900, 69484, 73053 and 73055; and
(e) excludes services described in the following items:

65079, 65082, 65157, 65158, 65166, 65180, 65181, 66606, 66609, 66610, 66639, 66642, 66651, 66652, 66663, 66666, 66696, 66697, 66714, 66715, 66723, 66724, 66780, 66783, 66789, 66790, 66792, 66804, 66805, 66816, 66817, 66820, 66821, 66826, 66827, 66832, 69325, 69328, 69331, 69379, 69383, 69400, 69401, 69419, 69451, 69500, 69484, 69489, 69492, 69497, 69498, 71076, 71090, 71092, 71096, 71148, 71154, 71156, 71169, 71170, 73309, 73312, 73315, 73318, 73321 and 73324;

where those services are performed by an approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority following referral by another approved pathology practitioner in an accredited pathology laboratory of an approved pathology authority which is not **related to** the first mentioned approved pathology authority.

(1A) An approved pathology authority is **related to** another approved pathology authority for the purposes of paragraph 18(1)(e) if that approved pathology authority would be related to the other approved pathology authority for the purposes of rule 16(2).

18. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

18. (3) If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and
(b) either:
(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or
(ii) if 2 or more items that describe any of those services specify the second-highest fee — the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and

(c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.

18. (5) If pathology services are to be treated as 1 pathology service under paragraph (3) (c) or (4) (c), the fee for the 1 pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

Hepatitis C viral RNA testing

19. For item 69499 and 69500:
Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain, for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

20. For items 73317 and 73318:
elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Serum B12 and red cell folate testing

21. (1) For items 66599 and 66602, a medicare benefit is not payable for more than 3 episodes of services described in item 66599 or 66602, or any combination of those items, in a 12 month period.

21. (2) A medicare benefit is not payable for a service described in item 66599 if the service was provided as part of the same patient episode as a service described in item 66602.

Nutritional and toxicity metals testing

22. (1) For this rule:
nutritional metals testing group means items 66819, 66820, 66821 and 66822.
metal toxicity testing group means items 66825, 66826, 66827, 66828, 66831 and 66832.

22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:
(a) that item; or
(b) the other item in the same group; or
(c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23. A request for Antineutrophil Cytoplasmic Antibody immunofluorescence test (ANCA) shall be deemed to include requests for antineutrophil proteinase 3 antibody test (PR-3 ANCA) and antimyeloperoxidase antibody test (MPO ANCA) where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or those specific antibodies have been previously detected.

Satisfying Requirements Described in Items

24. Unless stated elsewhere in these rules, where an item contains a requirement, this requirement is satisfied if:
(a) The requirement/s as stipulated in the item descriptor are contained in the request form; or
(b) The requirement/s as stipulated in the item descriptor were supplied previously in writing to the APA and this documentation is retained by the APA; or
(c) The results of other laboratory tests performed in the same episode meet the requirement/s as stipulated in the item descriptor; or
(d) The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are supplied on the request form; or
The results of laboratory tests that meet the requirement/s as stipulated in the item descriptor are contained in the APA's records.

Limitation on certain items

25. (a) For any particular patient, items 66539, 66605, 66606, 66607, 66610, 69380, 69488, 69489, 71075, 71127, 71135 or 71137 is applicable not more than twice in a 12 month period.
(b) For any particular patient, item 66626 is applicable not more than 36 times in a 12 month period.
(c) For any particular patient, items 66655, 66659, 69482, 69491, 69499 or 69500 are applicable not more than once in a 12 month period.
(d) For any particular patient, item 66750 or 66751 is applicable not more than once in a pregnancy.
(e) For any particular patient, item 69336 is applicable not more than once in each period of 7 days.
(f) For any particular patient, items 66551, 66660, 69445, 69451, 69483, 71079 or 73523 are applicable not more than 4 times in a 12 month period.
(g) For any particular patient, items 66554, 66830 and 71077 are applicable not more than 6 times in a 12 month period.
(h) For any particular patient, item 66819, 66820, 66821, 66822, 66825, 66826, 66827 or 66828 is applicable not more than 3 times in a 6 month period.
(i) For any particular patient, items 69418 and 69419 are applicable not more than twice in a 24 month period.

Antigen Detection – Group P3 (Microbiology)

26. If the service listed in 69316, 69317, 69319, 69494, 69495, 69496, 69497 or 69498 is a pathologist determinable service the specialist pathologist is required to record the reasons for determining the need for this service.

27. If the service rendered in 71148, 73320 or 73321 is a pathologist determinable service, the specialist pathologist is required to record the reason for determining the need for this service including the result of the service in 71147.

Table for Cross Referencing Rules and Clauses appearing in Regulations

1 Nov 2010 MBS Book Rules	**Health Insurance (Pathology Services Table) Regulations 2010 Clauses**					
1	Dictionary					
2	1.2.1	2.12.1				
3	1.2.2					
4	1.2.3	2.1.1	2.2.2			
5	2.1.2					
6	1.2.4					
7	1.2.5					
8	2.2.1					
9	2.2.5					
10	2.3.1					
11	2.3.3					
12	2.4.2					
13	2.5.1	2.6.1				
14	2.10.1	2.11.1				
15	2.11.2					
16	2.11.3					
17	1.1.1					
18	1.2.6					
18A	1.2.7					
19	2.3.5					
20	2.7.1					
21	2.2.4					
22	2.2.7					
23	2.4.4					
24	1.2.8	2.4.5				
25	2.2.3	2.2.6	2.2.7	2.3.4	2.4.1	2.8.1
26	2.3.2					
27	2.4.3	2.7.2				

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.

GROUP P1 - HAEMATOLOGY

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

PATHOLOGY				PATHOLOGY
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

GROUP P2 - CHEMICAL

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

	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period		
66557	**Fee:** $9.75	**Benefit:** 75% = $7.35	85% = $8.30
	Microalbumin - quantitation in urine		
66560	**Fee:** $20.25	**Benefit:** 75% = $15.20	85% = $17.25
	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests		
66563	**Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15
	Quantitation of: (a) blood gases (including pO_2, oxygen saturation and pCO_2); 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		
66566	**Fee:** $33.95	**Benefit:** 75% = $25.50	85% = $28.90
	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day		
66569	**Fee:** $42.90	**Benefit:** 75% = $32.20	85% = $36.50
	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day		
66572	**Fee:** $51.90	**Benefit:** 75% = $38.95	85% = $44.15
	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day		
66575	**Fee:** $60.85	**Benefit:** 75% = $45.65	85% = $51.75
	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day		
66578	**Fee:** $69.80	**Benefit:** 75% = $52.35	85% = $59.35
	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day		
66581	**Fee:** $78.80	**Benefit:** 75% = $59.10	85% = $67.00
	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test		
66584	**Fee:** $9.75	**Benefit:** 75% = $7.35	85% = $8.30
	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		
66587	**Fee:** $47.85	**Benefit:** 75% = $35.90	85% = $40.70
	Calculus, analysis of 1 or more		
66590	**Fee:** $30.80	**Benefit:** 75% = $23.10	85% = $26.20
	Ferritin - quantitation, except if requested as part of iron studies		
66593	**Fee:** $18.10	**Benefit:** 75% = $13.60	85% = $15.40
	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin		
66596	**Fee:** $32.75	**Benefit:** 75% = $24.60	85% = $27.85
	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 21)		
66599	**Fee:** $23.75	**Benefit:** 75% = $17.85	85% = $20.20
	Serum B12 and red cell folate and, if required, serum folate (Item is subject to rule 21)		
66602	**Fee:** $43.25	**Benefit:** 75% = $32.45	85% = $36.80
	Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests		
66605	**Fee:** $30.80	**Benefit:** 75% = $23.10	85% = $26.20
	A test described in item 66605 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18 and 25)		
66606	**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

	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)		
66651	**Fee:** $24.50	**Benefit:** 75% = $18.40	85% = $20.85
	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)		
66652	**Fee:** $20.45	**Benefit:** 75% = $15.35	85% = $17.40
	2 or more tests described in item 66650 (Item is subject to rule 6)		
66653	**Fee:** $44.90	**Benefit:** 75% = $33.70	85% = $38.20
	Prostate specific antigen - quantitation - 1 of this item in a 12 month period (Item is subject to rule 25)		
66655	**Fee:** $20.30	**Benefit:** 75% = $15.25	85% = $17.30
	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655)		
66656	**Fee:** $20.30	**Benefit:** 75% = $15.25	85% = $17.30
	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)		
66659	**Fee:** $37.55	**Benefit:** 75% = $28.20	85% = $31.95
	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)		
66660	**Fee:** $37.55	**Benefit:** 75% = $28.20	85% = $31.95
	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		
66662	**Fee:** $80.50	**Benefit:** 75% = $60.40	85% = $68.45
	A test described in item 66662 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)		
66663	**Fee:** $80.50	**Benefit:** 75% = $60.40	85% = $68.45
	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		
66665	**Fee:** $30.80	**Benefit:** 75% = $23.10	85% = $26.20
	A test described in item 66665 if rendered by a receiving APP - 1 or more tests (Item is subject to rule 18)		
66666	**Fee:** $30.80	**Benefit:** 75% = $23.10	85% = $26.20
	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test		
66667	**Fee:** $30.80	**Benefit:** 75% = $23.10	85% = $26.20
	Quantitation of serum aluminium in a patient in a renal dialysis program - each test		
66671	**Fee:** $37.15	**Benefit:** 75% = $27.90	85% = $31.60
	Quantitation of: (a) faecal fat; or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period		
66674	**Fee:** $40.20	**Benefit:** 75% = $30.15	85% = $34.20
	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old		
66677	**Fee:** $11.25	**Benefit:** 75% = $8.45	85% = $9.60
	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests		
66680	**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

	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751		
66743	**Fee:** $20.25	**Benefit:** 75% = $15.20	85% = $17.25
	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		
66749	**Fee:** $33.15	**Benefit:** 75% = $24.90	85% = $28.20
	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 (uE_3), 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)		
66750	**Fee:** $40.00	**Benefit:** 75% = $30.00	85% = $34.00
	Quantitation, in pregnancy, of any three or more tests described in 66750 (Item is subject to rule 25)		
66751	**Fee:** $55.60	**Benefit:** 75% = $41.70	85% = $47.30
	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		
66752	**Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15
	2 or more tests described in item 66752		
66755	**Fee:** $39.10	**Benefit:** 75% = $29.35	85% = $33.25
	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.		
66756	**Fee:** $98.95	**Benefit:** 75% = $74.25	85% = $84.15
	Quantitation of 10 or more amino acids for monitoring of previously diagnosed inborn errors of metabolism in 1 tissue type.		
66757	**Fee:** $98.95	**Benefit:** 75% = $74.25	85% = $84.15
	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests		
66758	**Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15
	Test for reducing substances in faeces by any method (except reagent strip or dipstick)		
66761	**Fee:** $13.25	**Benefit:** 75% = $9.95	85% = $11.30
	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		
66764	**Fee:** $8.95	**Benefit:** 75% = $6.75	85% = $7.65
	2 examinations described in item 66764 performed on separately collected and identified specimens		
66767	**Fee:** $17.95	**Benefit:** 75% = $13.50	85% = $15.30
	3 examinations described in item 66764 performed on separately collected and identified specimens		
66770	**Fee:** $26.90	**Benefit:** 75% = $20.20	85% = $22.90
	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)*		
66773	***Fee:** $24.80*	***Benefit:** 75% = $18.60*	*85% = $21.10*
	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		
66776	**Fee:** $24.80	**Benefit:** 75% = $18.60	85% = $21.10
	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		
66779	**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	Porphyrins or porphyrins 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	Porphyrins or porphyrins 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	Porphyrins or porphyrins 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

PATHOLOGY		PATHOLOGY
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 13CO2 or 14CO2 (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*	

GROUP P3 - MICROBIOLOGY

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

	A test described in item 69324 if rendered by a receiving APP (Item is subject to rule 18)		
69325	**Fee:** $43.30	**Benefit:** 75% = $32.50	85% = $36.85
	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		
69327	**Fee:** $85.55	**Benefit:** 75% = $64.20	85% = $72.75
	A test described in item 69327 if rendered by a receiving APP (Item is subject to rule 18)		
69328	**Fee:** $85.55	**Benefit:** 75% = $64.20	85% = $72.75
	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		
69330	**Fee:** $128.85	**Benefit:** 75% = $96.65	85% = $109.55
	A test described in item 69330 if rendered by a receiving APP (Item is subject to rule 18)		
69331	**Fee:** $128.85	**Benefit:** 75% = $96.65	85% = $109.55
	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 suseptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts		
69333	**Fee:** $20.70	**Benefit:** 75% = $15.55	85% = $17.60
	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		
69336	**Fee:** $33.65	**Benefit:** 75% = $25.25	85% = $28.65
	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		
69339	**Fee:** $19.25	**Benefit:** 75% = $14.45	85% = $16.40
	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		
69345	**Fee:** $53.25	**Benefit:** 75% = $39.95	85% = $45.30
	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		
69354	**Fee:** $30.95	**Benefit:** 75% = $23.25	85% = $26.35
	2 sets of cultures described in item 69354		
69357	**Fee:** $61.85	**Benefit:** 75% = $46.40	85% = $52.60
	3 sets of cultures described in item 69354		
69360	**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% = $701.80
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

	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)*
69396	**Fee:** $69.55 **Benefit:** 75% = $52.20 85% = $59.15
	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)
69400	**Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
	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)
69401	**Fee:** $13.45 **Benefit:** 75% = $10.10 85% = $11.45
	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)*
69405	**Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
	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)*
69408	**Fee:** $29.20 **Benefit:** 75% = $21.90 85% = $24.85
	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)*
69411	**Fee:** $42.65 **Benefit:** 75% = $32.00 85% = $36.30
	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)*
69413	**Fee:** $56.10 **Benefit:** 75% = $42.10 85% = $47.70
	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 Hepatitus B, Hepatitus 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)*
69415	**Fee:** $69.55 **Benefit:** 75% = $52.20 85% = $59.15
	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)
69418	**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

	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		
69491	**Fee:** $206.20	**Benefit:** 75% = $154.65	85% = $175.30
	A test described in item 69491 if rendered by a receiving APP - 1 test (Item is subject to rule 18 and 25)		
69492	**Fee:** $206.20	**Benefit:** 75% = $154.65	85% = $175.30
	Detection of a virus or microbial antigen or microbial nucleic acid (not elsewhere specified) 1 test (Item is subject to rule 6 and 26)		
69494	**Fee:** $28.85	**Benefit:** 75% = $21.65	85% = $24.55
	2 tests described in 69494 (Item is subject to rule 6 and 26)		
69495	**Fee:** $36.10	**Benefit:** 75% = $27.10	85% = $30.70
	3 or more tests described in 69494 (Item is subject to rule 6 and 26)		
69496	**Fee:** $43.35	**Benefit:** 75% = $32.55	85% = $36.85
	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)		
69497	**Fee:** $28.85	**Benefit:** 75% = $21.65	85% = $24.55
	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)		
69498	**Fee:** $7.25	**Benefit:** 75% = $5.45	85% = $6.20
	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)		
69499	**Fee:** $92.80	**Benefit:** 75% = $69.60	85% = $78.90
	A test described in item 69499 if rendered by a receiving APP – 1 test (Item is subject to rule 18,19 and 25)		
69500	**Fee:** $92.80	**Benefit:** 75% = $69.60	85% = $78.90

GROUP P4 - IMMUNOLOGY

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

	Detection of 4 or more antibodies specified in item 71119		
71125	**Fee:** $27.85	**Benefit:** 75% = $20.90	85% = $23.70
	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		
71127	**Fee:** $177.55	**Benefit:** 75% = $133.20	85% = $150.95
	2 tests described in item 71127		
71129	**Fee:** $219.30	**Benefit:** 75% = $164.50	85% = $186.45
	3 or more tests described in item 71127		
71131	**Fee:** $261.10	**Benefit:** 75% = $195.85	85% = $221.95
	Investigation of recurrent infection by qualitative assessment for the presence of defects in oxidative pathways in neutrophils by the nitroblue tetrazolium (NBT) reduction test		
71133	**Fee:** $10.45	**Benefit:** 75% = $7.85	85% = $8.90
	Investigation of recurrent infection by quantitative assessment of oxidative pathways by flow cytometric techniques, including a test described in 71133 (if performed)		
71134	**Fee:** $104.75	**Benefit:** 75% = $78.60	85% = $89.05
	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		
71135	**Fee:** $209.35	**Benefit:** 75% = $157.05	85% = $177.95
	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		
71137	**Fee:** $30.45	**Benefit:** 75% = $22.85	85% = $25.90
	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		
71139	**Fee:** $104.75	**Benefit:** 75% = $78.60	85% = $89.05
	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		
71141	**Fee:** $198.70	**Benefit:** 75% = $149.05	85% = $168.90
	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		
71143	**Fee:** $261.75	**Benefit:** 75% = $196.35	85% = $222.50
	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		
71145	**Fee:** $427.35	**Benefit:** 75% = $320.55	85% = $363.25
	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 pherisis collection		
71146	**Fee:** $104.75	**Benefit:** 75% = $78.60	85% = $89.05
	HLA-B27 typing (Item is subject to rule 27)		
71147	**Fee:** $40.80	**Benefit:** 75% = $30.60	85% = $34.70

	A test described in item 71147 if rendered by a receiving APP. (Item is subject to rule 18 and 27)		
71148	**Fee:** $40.80	**Benefit:** 75% = $30.60	85% = $34.70
	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		
71149	**Fee:** $109.00	**Benefit:** 75% = $81.75	85% = $92.65
	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		
71151	**Fee:** $119.65	**Benefit:** 75% = $89.75	85% = $101.75
	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 antiglomerular basement membrane antibody (GBM test) - detection of 1 antibody (Item is subject to rule 6 and 23)		
71153	**Fee:** $34.80	**Benefit:** 75% = $26.10	85% = $29.60
	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)		
71154	**Fee:** $34.80	**Benefit:** 75% = $26.10	85% = $29.60
	Detection of 2 antibodies described in item 71153 (Item is subject to rule 6 and 23)		
71155	**Fee:** $47.75	**Benefit:** 75% = $35.85	85% = $40.60
	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)		
71156	**Fee:** $12.95	**Benefit:** 75% = $9.75	85% = $11.05
	Detection of 3 antibodies described in item 71153 (Item is subject to rule 6 and 23)		
71157	**Fee:** $60.70	**Benefit:** 75% = $45.55	85% = $51.60
	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 6 and 23)		
71159	**Fee:** $73.65	**Benefit:** 75% = $55.25	85% = $62.65
	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		
71163	**Fee:** $24.90	**Benefit:** 75% = $18.70	85% = $21.20
	Two or more tests described in 71163 and including a service described in 71066 (if performed)		
71164	**Fee:** $40.15	**Benefit:** 75% = $30.15	85% = $34.15
	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)		
71165	**Fee:** $34.80	**Benefit:** 75% = $26.10	85% = $29.60
	Detection of 2 antibodies described in item 71165 (Item is subject to rule 6)		
71166	**Fee:** $47.75	**Benefit:** 75% = $35.85	85% = $40.60
	Detection of 3 antibodies described in item 71165 (Item is subject to rule 6)		
71167	**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 cytotoxity assay prior to the initiation of Abacavir therapy including item 73323 if performed. **Fee:** $40.80	**Benefit:** 75% = $30.60	85% = $34.70

	GROUP P5 - TISSUE PATHOLOGY		
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 complexicity 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

GROUP P6 - CYTOLOGY

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

GROUP P7 - GENETICS

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 monitoringof 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% = $520.15
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-PDGFRA 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

PATHOLOGY				PATHOLOGY
	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			
73327	**Fee:** $52.30	**Benefit:** 75% = $39.25	85% = $44.50	

GROUP P8 - INFERTILITY AND PREGNANCY TESTS

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

	GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS		
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
73811	Mantoux test **Fee:** $11.30	**Benefit:** 75% = $8.50	85% = $9.65
New 73828	Semen examination for presence of spermatozoa by a participating nurse practitioner **Fee:** $6.95	**Benefit:** 85% = $5.95	
New 73829	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count by a participating nurse practitioner - 1 test **Fee:** $4.60	**Benefit:** 85% = $3.95	
New 73830	2 tests described in item 73829 by a participating nurse practitioner **Fee:** $6.40	**Benefit:** 85% = $5.45	
New 73831	3 or more tests described in item 73829 by a participating nurse practitioner **Fee:** $8.20	**Benefit:** 85% = $7.00	
New 73832	Microscopy of urine, whether stained or not, or catalase test by a participating nurse practitioner **Fee:** $4.60	**Benefit:** 85% = $3.95	
New 73833	Pregnancy test by 1 or more immunochemical methods by a participating nurse practitioner **Fee:** $10.20	**Benefit:** 85% = $8.70	
New 73834	Microscopy for wet film other than urine, including any relevant stain by a participating nurse practitioner **Fee:** $6.95	**Benefit:** 85% = $5.95	
New 73835	Microscopy of Gram-stained film, including (if performed) a service described in item 73832 or 73834 by a participating nurse practitioner **Fee:** $8.70	**Benefit:** 85% = $7.40	
New 73836	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method by a participating nurse practitioner **Fee:** $2.35	**Benefit:** 85% = $2.00	
New 73837	Microscopy for fungi in skin, hair or nails by a participating nurse practitioner – 1 or more sites **Fee:** $6.95	**Benefit:** 85% = $5.95	

GROUP P10 - PATIENT EPISODE INITIATION

73920	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre that the APA operates in the same premises as it operates a category GX or GY pathology laboratory **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73922	Initiation of a patient episode that consists only of a service described in item 73053, 73055 or 73057. Unless item 73923 applies **Fee:** $8.25	**Benefit:** 75% = $6.20	85% = $7.05
73923	Initiation of a patient episode that consists only of a service described in items 73053, 73055 or 73057 from a person who is a private patient in a recognised hospital or the service is rendered by a prescribed laboratory **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73924	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 from a person who is an in-patient of a hospital. Unless item 73925 applies **Fee:** $14.75	**Benefit:** 75% = $11.10	85% = $12.55
73925	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 from a person who is a private patient in a recognised hospital or the service is rendered to a private patient in a hospital by a prescribed laboratory **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73926	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 from a person who is not an in-patient of a private hospital. Unless item 73927 applies. **Fee:** $8.25	**Benefit:** 75% = $6.20	85% = $7.05
73927	Initiation by a prescribed laboratory of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 from a person who is not a private patient in a recognised hospital nor a patient in a private hospital **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73928	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected in an approved collection centre. Unless item 73920 or 73929 applies **Fee:** $6.00	**Benefit:** 75% = $4.50	85% = $5.10
73929	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, if the specimen is collected in an approved pathology collection centre **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73930	Initiation of a patient episode by collection of a specimen for a service for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person who is an in-patient of a hospital other than a recognised hospital. Unless item 73931 applies **Fee:** $6.00	**Benefit:** 75% = $4.50	85% = $5.10
73931	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if: (b) the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person who is a private patient in a hospital or (c) the person is a private patient in a recognised hospital and the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority **Fee:** $2.40	**Benefit:** 75% = $1.80	85% = $2.05
73932	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing. Unless item 73933 applies **Fee:** $10.30	**Benefit:** 75% = $7.75	85% = $8.80

73933	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner for a prescribed laboratory or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in the place where the person is residing **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73934	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 and 73926) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a residential aged care home or institution. Unless 73935 applies **Fee:** $17.70 **Benefit:** 75% = $13.30 85% = $15.05
73935	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by an approved pathology practitioner or by an employee of an approved pathology authority, who conducts a prescribed laboratory, from a person in a residential aged care home or institution **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73936	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected from the person by the person. **Fee:** $6.00 **Benefit:** 75% = $4.50 85% = $5.10
73937	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected from the person by the person and if: (d) the service is performed in a prescribed laboratory or (e) the person is a private patient in a recognised hospital **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05
73938	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926) if the specimen is collected by or on behalf of the treating practitioner. Unless item 73939 applies **Fee:** $8.00 **Benefit:** 75% = $6.00 85% = $6.80
73939	Initiation of a patient episode by collection of a specimen for 1 or more services (other than those services described in items 73922, 73924 or 73926), if the specimen is collected by or on behalf of the treating practitioner and if: (f) the service is performed in a prescribed laboratory or (g) the person is a private patient in a recognised hospital **Fee:** $2.40 **Benefit:** 75% = $1.80 85% = $2.05

	GROUP P11 - SPECIMEN REFERRED
73940	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to rules 14, 15 and 16) **Fee:** $10.30 **Benefit:** 75% = $7.75 85% = $8.80

GROUP P12 - MANAGEMENT OF BULK-BILLED SERVICES

A pathology service to which an item in this table (other than this item or item 74991) applies if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is bulk-billed in respect of the fees for:

(i) this item; and

(ii) the other item in this table applying to the service

(See para P16.13 of explanatory notes to this Category)

74990 **Fee:** $6.90 **Benefit:** 85% = $5.90

A pathology service to which an item in this table (other than this item or item 74990) applies if:

(a) the service is an unreferred service; and

(b) the service is provided to a person who is under the age of 16 or is a Commonwealth concession card holder; and

(c) the person is not an admitted patient of a hospital; and

(d) the service is bulk-billed in respect of the fees for:

(i) this item; and

(ii) the other item in this table applying to the service; and

(e) the service is provided at, or from, a practice location in:

(i) a regional, rural or remote area; or

(ii) Tasmania; or

(iii) A geographical area included in any of the following SSD spatial units:

(A) Beaudesert Shire Part A
(B) Belconnen
(C) Darwin City
(D) Eastern Outer Melbourne
(E) East Metropolitan, Perth
(F) Frankston City
(G) Gosford-Wyong
(H) Greater Geelong City Part A
(I) Gungahlin-Hall
(J) Ipswich City (part in BSD)
(K) Litchfield Shire
(L) Melton-Wyndham
(M) Mornington Peninsula Shire
(N) Newcastle
(O) North Canberra
(P) Palmerston-East Arm
(Q) Pine Rivers Shire
(R) Queanbeyan
(S) South Canberra
(T) South Eastern Outer Melbourne
(U) Southern Adelaide
(V) South West Metropolitan, Perth
(W) Thuringowa City Part A
(X) Townsville City Part A
(Y) Tuggeranong
(Z) Weston Creek-Stromlo
(ZA) Woden Valley
(ZB) Yarra Ranges Shire Part A; or

(iv) the geographical area included in the SLA spatial unit of Palm Island (AC)

(See para P16.13 of explanatory notes to this Category)

74991 **Fee:** $10.45 **Benefit:** 85% = $8.90

	GROUP P13 - BULK BILLED PATHOLOGY EPISODE INCENTIVE ITEMS
74992	A payment when the episode is bulk billed and includes item 73920. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40
74993	A payment when the episode is bulk billed and includes item 73922 or 73926. **Fee:** $3.75 **Benefit:** 75% = $2.85 85% = $3.20
74994	A payment when the episode is bulk billed and includes item 73924. **Fee:** $3.25 **Benefit:** 75% = $2.45 85% = $2.80
74995	A payment when the episode is bulk billed and includes item 73928, 73930 or 73936. **Fee:** $4.00 **Benefit:** 75% = $3.00 85% = $3.40
74996	A payment when the episode is bulk billed and includes item 73932 or 73940. **Fee:** $3.70 **Benefit:** 75% = $2.80 85% = $3.15
74997	A payment when the episode is bulk billed and includes item 73934. **Fee:** $3.30 **Benefit:** 75% = $2.50 85% = $2.85
74998	A payment when the episode is bulk billed and includes item 73938. **Fee:** $2.00 **Benefit:** 75% = $1.50 85% = $1.70
74999	A payment when the episode is bulk billed and includes item 73923, 73925,73927, 73929, 73931, 73933, 73935, 73937 or 73939. **Fee:** $1.60 **Benefit:** 75% = $1.20 85% = $1.40

INDEX

D

E

F

G

H

N

O

P