Medicare Benefits Schedule Review Taskforce

Final report from the Obstetrics Clinical Committee

2016

Important note

The recommendations from the Obstetrics Clinical Committee detailed in the body of this report, including the executive summary, were released for public consultation on 9 September 2016.

The Obstetrics Clinical Committee considered feedback from the public consultation and made minor changes to a number of recommendations which are detailed in the addendum to this report.

The final recommendations from the Obstetrics Clinical Committee and feedback from the public consultation will be provided to the Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) for consideration before the Taskforce makes its final recommendations to Government.

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1. Executive Summary

The Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) is undertaking a program of work that considers how more than 5,700 items on the MBS can be aligned with contemporary clinical evidence and practice and improves health outcomes for patients. The Taskforce will also seek to identify any services that may be unnecessary, outdated or potentially unsafe.

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- Affordable and universal access
- Best practice health services
- Value for the individual patient
- Value for the health system.

The Taskforce has endorsed a methodology whereby the necessary clinical review of MBS items is undertaken by Clinical Committees and Working Groups. The Taskforce has asked the Clinical Committees to undertake the following tasks:

1. Consider whether there are MBS items that are obsolete and should be removed from the MBS.
2. Consider identified priority reviews of selected MBS services.
3. Develop a program of work to consider the balance of MBS services within its remit and items assigned to the Committee.
4. Advise the Taskforce on relevant general MBS issues identified by the Committee in the course of its deliberations.

The recommendations from the Clinical Committees are released for stakeholder consultation. The Clinical Committees will consider feedback from stakeholders and then provide recommendations to the Taskforce in a Review Report. The Taskforce will consider the Review Report from Clinical Committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

The Obstetrics Clinical Committee (the Committee) was established in 2015 to make recommendations to the MBS Review Taskforce on the review of MBS items in its area of responsibility, based on rapid evidence review and clinical expertise. The Taskforce asked the Committee to review prenatal pathology testing as a priority review.

1.1 Areas of responsibility of the Obstetrics Clinical Committee

The following 99 MBS items were identified for review by the Obstetrics Clinical Committee. A full list of items and descriptions are listed in Appendix A.

- Therapeutic procedures: Obstetrics
  - 16399 to 16363 (42 items)
- Therapeutic procedures: Gynaecology

- 35676 to 35677 (2 items)

- Assistance at caesarean
  - 51306, 51309, 51312 (3 items)
- Diagnostic imaging services: Obstetric ultrasound (in conjunction with the Diagnostic Imaging Clinical Committee)
  - 55700 to 55775 (50 items)
- Diagnostic imaging services: Radiographic examination in connection with pregnancy (in conjunction with the Diagnostic Imaging Clinical Committee)
  - 59503 to 59504 (2 items)
- Pathology services specifically related to pregnancy
  - Not listed as the Pathology Clinical Committee will have primary responsibility for these items.

1.2 Key recommendations

1.2.1 Significant amendments for selected items

The Committee recommends that a number of items be significantly amended to ensure the clinical criteria are appropriate, and to reduce perceived financial incentives to provide more complex care.

1. 16522 – Complex delivery

The Committee has revised the clinical indications for this item to provide clarity to doctors regarding appropriate use and to reduce unexplained variation in claiming patterns. More detail is in Section 5.1.

2. 16590 – Planning and management of a pregnancy - doctor intends to undertake the delivery

The Committee recommends delaying the date for claiming this item to 28 weeks gestation (from the current 20 weeks) and including a requirement that the provider has hospital privileges for intrapartum care to reduce inappropriate claiming of this item. The Committee is also including a requirement that a mental health assessment is undertaken. The Committee recommends that the fee for item 16590 is increased to reflect that the provider must be continuously available during the pregnancy and the additional requirement to undertake a mental health assessment. More detail is in Section 5.2.

3. 16591 – Planning and management of a pregnancy – doctor does not intend to undertake the delivery

The Committee recommends delaying the date for claiming this item to 28 weeks gestation (from the current 20 weeks) to reduce inappropriate claiming of this item; and including a requirement that a mental health assessment is undertaken. More detail is in Section 5.3.

4. 16525 –Management of second trimester fetal loss

The Committee notes that there is currently one item for management of second trimester labour and that many patients are transferred to the public system for this service. The Committee

recommends that item 16525 is split into two, with the management of early pregnancy loss between 14.0 – 15.6 weeks gestation retaining the current fee ($384.35), and the management of pregnancy loss between 16 and 22.6 weeks gestation attracting a higher fee ($768.70). This reflects the additional time and complexity associated with management late second trimester fetal loss, and the higher risk of maternal complications and the need for more intensive patient counselling. It is anticipated that fewer patients will be referred to the public system which will improve continuity of care for these patients. This change will not change access to these services. More detail is in Section 5.4.

5. **Items for vaginal birth and caesarean section where the patient is transferred by another medical practitioner**

The Committee recommends that items 16515 (vaginal delivery) and 16520 (caesarean section) have the same fee and that it is set in the middle of the current fees for item 16515 and 16520 to align with the principal birth item (16519) which does not distinguish between a vaginal and operative delivery. More detail is in Section 5.5.

6. **Items for vaginal birth and caesarean section where the patient is transferred by a participating midwife**

The Committee recommends that items 16527 (vaginal delivery) and 16528 (caesarean section) have the same fee and that is set in the middle of the current fees for item 16527 and 16528 to align with the principal birth item (16519) which does not distinguish between a vaginal and operative delivery. More detail is in Section 5.6.

1.2.2 New items

The Committee recommends a number of new items.

The Committee did not undertake a comprehensive review of the MBS fees for the items within scope. However, it concluded that the fees for some items do not reflect the time and complexity of work required to perform the services for some providers and has made recommendations to increase the fees for some services, requiring the introduction of new items.

1. **Attendances for pregnancy complications over 40 minutes (currently funded through the MBS items 16508 and 16509)**
    a) New item - Attendance over 40 minutes for pregnancy complicated by acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital.
    b) New item - Attendance over 40 minutes for preeclampsia, eclampsia or antepartum haemorrhage

The Committee considers that the management of conditions covered under item 16508 or item 16509 can be complex and prolonged, particularly in non-urban maternity units where there is less hospital support. The Committee recommends that new items be introduced for consultations over 40 minutes for the above clinical indications. More detail is in Section 6.1.

2. **Postnatal items (currently funded through the MBS – item 16404 for obstetrician and GP attendance items for GPs)**
    a) New item - Postnatal consultation by Obstetrician or General Practitioner, between one week and eight weeks after birth, which must include a mental health assessment

The Committee recommends a new item be introduced for a postnatal check of a patient that requires obstetricians or GPs to undertake a mental health assessment. All public and private patients will be eligible for this new item.

    a) New item - Postnatal consultation at home by obstetrician or general practitioner or registered midwife on behalf of, and under the supervision of a medical practitioner, between one and three weeks after birth, which must include a mental health assessment.

The Committee recommends a new item for a home visit between one and three weeks after birth that requires a mental health assessment. This item is only available for patients who were privately admitted for the birth. More detail is in Sections 6.2 and 6.3.

1.2.3 Obstetric services in rural and remote areas

The Committee recommends that the MBS Review Taskforce consider how to better support rural service delivery and in particular the role of financial incentives in supporting the provision of MBS funded health services in rural and remote Australia. More detail is in Section 7.

1.2.4 Items to be removed

The Committee recommends that items 16633 and 16636, which reduce the MBS benefits payable for procedures (for example amniocentesis) on the second and subsequent fetus, are removed. This change will increase the MBS benefits payable for patients who have procedures for multiple pregnancies. More detail is in Section 8.1.

The Committee notes there are two items for removal of ectopic pregnancy (35676 and 35677), and that the schedule fee when specialists provide this service is higher than when a general practitioner provides this service. The Committee recommends that item 35676 is removed and item 35677 is amended so that both general practitioners and specialists can claim this item and are paid at the higher specialist rate. More detail is in Section 8.2.

1.2.5 Obsolete items

The Committee has identified three obsolete items – injection of hormones for habitual miscarriage and two items for pelvimetry (an x-ray during pregnancy). The Committee recommends these items be removed from the MBS. More detail is in Section 9.1.

1.2.6 Items for minor amendments

The Committee recommends minor amendment to nine items to simplify wording, update terminology and to remove some claiming restrictions. These items are listed in Section 10.

1.2.7 Items not requiring amendment

The Committee advises that 23 items do not need amendment as these support clinically appropriate practice. Items that do not require amendment are listed in Table 23 in Section 11.

1.2.8 Priority Review recommendations

The Committee recommends there should be one item that includes all of the standard pathology tests that pregnant women should have done in the first trimester.

The tests to be included in this 'panel' are:

- **65070** – Full blood count
- **65096** – Blood grouping and examination of serum for Rh and other blood group antibodies
- **69333** – Urinalysis with MSU mcs
- **69415** – Hepatitis B, Hepatitis C, HIV, rubella, syphilis (item is for testing all five).

As this recommendation relates to pathology MBS items, it has been referred to the Pathology Clinical Committee for consideration. More detail is in Section 12.

1.2.9 Pregnancy ultrasounds

The Committee is finalising a number of recommendation regarding pregnancy ultrasounds which will be provided to the Diagnostic Imaging Clinical Committee for consideration.

1.3 Consumer engagement

The Obstetrics Clinical Committee undertook one of the first clinical reviews. Committee members include health professionals and a consumer representative. The Committee found that many MBS items for obstetric services work well and do not require any change. However, some items such as the management of a complex delivery and the planning and management of a pregnancy do require some changes.

The Obstetrics Clinical Committee believes it is important to find out from consumers if they will be helped or disadvantaged by the recommendations – and how, and why. Following the public consultation the Obstetrics Clinical Committee will assess the advice from consumers and decide whether any changes are needed to the recommendations. The Obstetrics Clinical Committee will then send the recommendations to the MBS Review Taskforce. The Taskforce will consider the recommendations as well as the information provided by consumers in order to make sure that all the important concerns are addressed. The Taskforce will then provide the recommendation to government.

The Review identified a number of issues:

- Some items covered by Medicare are not specific enough to guide doctors as to when items can be claimed.
- Some items are outdated and doctors don't use them often, if at all.

- Some items don't include important aspects of care that should be provided to patients, for example a mental health assessment.
- Sometimes the fees don't match the complexity of the service.

The Committee believes these recommendations will improve the quality of the obstetrics services that patients are provided.

A summary of the Committee's recommendations for consumers can be found at Appendix B.

2. About the Medicare Benefits Schedule (MBS) Review

2.1 Medicare and the MBS

What is Medicare?

Medicare is Australia's universal health scheme which enables all Australian residents (and some overseas visitors) to have access to a wide range of health services and medicines at little or no cost.

Introduced in 1984, Medicare has three components, being free public hospital services for public patients, subsidised drugs covered by the Pharmaceutical Benefits Scheme, and subsidised health professional services listed on the Medicare Benefits Schedule (MBS).

What is the Medicare Benefits Schedule (MBS)?

The Medicare Benefits Schedule (MBS) is a listing of the health professional services subsidised by the Australian government. There are over 5,700 MBS items which provide benefits to patients for a comprehensive range of services including consultations, diagnostic tests and operations.

2.2 What is the MBS Review Taskforce?

The Government has established a Medicare Benefits Schedule (MBS) Review Taskforce (the Taskforce) to review all of the 5,700 MBS items to ensure they are aligned with contemporary clinical evidence and practice and improve health outcomes for patients.

What are the goals of the Taskforce?

The Taskforce is committed to providing recommendations to the Minister that will allow the MBS to deliver on each of these four key goals:

- **Affordable and universal access**— the evidence demonstrates that the MBS supports very good access to primary care services for most Australians, particularly in urban Australia. However, despite increases in the specialist workforce over the last decade, access to many specialist services remains problematic with some rural patients being particularly under-serviced.
- **Best practice health services**— one of the core objectives of the Review is to modernise the MBS, ensuring that individual items and their descriptors are consistent with contemporary best practice and the evidence base where possible. Although the Medical Services Advisory Committee (MSAC) plays a crucial role in thoroughly evaluating new services, the vast majority of existing MBS items pre-date this process and have never been reviewed.
- **Value for the individual patient**—another core objective of the Review is to have a MBS that supports the delivery of services that are appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense.
- **Value for the health system**—achieving the above elements of the vision will go a long way to achieving improved value for the health system overall. Reducing the volume of services that provide little or no clinical benefit will enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.

2.3 Methods: The Taskforce's approach

The Taskforce is reviewing the existing MBS items, with a primary focus on ensuring that individual items and usage meet the definition of best practice.

Within the Taskforce's brief there is considerable scope to review and advise on all aspects which would contribute to a modern, transparent and responsive system. This includes not only making recommendations about new items or services being added to the MBS, but also about a MBS structure that could better accommodate changing health service models.

The Taskforce has made a conscious decision to be ambitious in its approach and seize this unique opportunity to recommend changes to modernise the MBS on all levels, from the clinical detail of individual items, to administrative rules and mechanisms, to structural, whole-of-MBS issues.

The Taskforce will also develop a mechanism for the ongoing review of the MBS once the current Review is concluded.

As the Review is to be clinician-led, the Taskforce has decided that the detailed review of MBS items should be done by Clinical Committees. The Committees are broad based in their membership and members have been appointed in their individual capacity, not as representatives of any organisation. This draft report details the work done by the specific Clinical Committee and describes the Committee's recommendations and their rationale.

This report does not represent the final position of the Committee. A consultation process will inform recommendations of the Committee and assist it in finalising its report to the MBS Review Taskforce.

Following consultation, the Committee will provide its final advice to the MBS Review Taskforce. The Taskforce will consider the Review Report from Clinical Committees and stakeholder feedback before making recommendations to the Minister for consideration by Government.

2.4 Prioritisation process

All MBS items will be reviewed during the course of the MBS Review. However, given the breadth of and timeframe for the Review, each Clinical Committee has needed to develop a work plan and assign priorities keeping in mind the objectives of the Review. With a focus on improving the clinical value of MBS services, the Clinical Committees have taken account of factors including the volume of services, service patterns and growth and variation in the per capita use of services, to prioritise their work. In addition to MBS data, important resources for the Taskforce and the Clinical Committees have included:

- The Choosing Wisely recommendations, both from Australian and internationally
- National Institute for Health and Care Excellence (NICE UK) Do Not Do recommendations and clinical guidance
- Other literature on low value care, including Elshaug et al's[i] Medical Journal of Australia article on potentially low value health services
- The Australian Commission on Safety and Quality in Health Care's (ACSQHC) Atlas of Healthcare Variation.

3. About the Obstetrics Committee

The Obstetrics Clinical Committee is part of the first tranche of committees.

The Obstetrics Clinical Committee (the Committee) was established in 2015 to make recommendations to the MBS Review Taskforce on the review of MBS items within its remit, based on rapid evidence review and clinical expertise. The Taskforce has asked the Committee to review prenatal pathology testing as a priority review.

3.1 Obstetrics Clinical Committee members

Table 1: Obstetrics Clinical Committee Members

Name	Position/Organisation	Declared conflict of interest
Professor Michael Permezel (Chair)	Consultant Obstetrician, Mercy Hospital for Women; Professor of Obstetrics and Gynaecology, University of Melbourne; President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Nil
Dr Vijay Roach	Consultant Obstetrician & Gynaecologist, Royal North Shore Hospital; Obstetrician, private practice; Vice-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Provider of MBS funded services reviewed by this Committee
Professor Stephen Robson	Consultant Obstetrician & Gynaecologist, Canberra Hospital; Obstetrician, private practice; Vice-President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Professor, Australian National University; President-Elect, Australian Medical Association ACT	Provider of MBS funded services reviewed by this Committee
Dr Louise Sterling	GP Obstetrician, private practice	Provider of MBS funded services reviewed by this Committee
Professor Lucie Walters	Professor, Rural Medical Education, Flinders University; Obstetrician, private practice (rural); President, Australian College of Rural and Remote Medicine	Provider of MBS funded services reviewed by this Committee
Professor Jonathan Morris	Director, Kolling Institute for Medical Research, University of Sydney	Provider of MBS funded services reviewed by this Committee

Name	Position/Organisation	Declared conflict of interest
Ms Elizabeth Wilkes	Chief Executive Officer, Midwifery and Maternity Provider Organisation Australia; Midwife, private practice	Nil
Dr Christine Thevathasan	Consultant Obstetrician & Gynaecologist, Sandringham Hospital; Secretary, National Association of Specialist Obstetricians and Gynaecologists; Obstetrician, private practice	Provider of MBS funded services reviewed by this Committee
Professor Elizabeth Sullivan	Professor Public Health, Assistant Deputy Vice Chancellor Research, University of Technology Sydney. Perinatal Epidemiologist	Nil
Ms Julie Hamblin	Lawyer, HWL Ebsworth; Consumer	Nil
Dr Debbie Nisbet	Consultant Obstetric & Gynaecological Ultrasonologist, Royal Women's Hospital Melbourne; Chair, Certification in Obstetric and Gynaecological Ultrasound Committee, Royal Australian and New Zealand College of Obstetricians and Gynaecologists; Ultrasonologist, private practice	Provider of MBS funded services reviewed by this Committee

3.2 GP Share Antenatal Care Working Group members

Table 2: GP Shared Antenatal Care Working Group Members

Name	Position/Organisation	Declared conflict of interest
Professor Michael Permezel (Chair)	Consultant Obstetrician, Mercy Hospital for Women; Professor of Obstetrics and Gynaecology, University of Melbourne; President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists	Nil
Dr Louise Sterling	GP Obstetrician, private practice	Provider of MBS funded services reviewed by this Committee

Name	Position/Organisation	Declared conflict of interest
Professor Lucie Walters	Professor, Rural Medical Education, Flinders University; Obstetrician, private practice (rural); President, Australian College of Rural and Remote Medicine	Provider of MBS funded services reviewed by this Committee
Dr Wendy Burton	GP, private practice; Chair, Antenatal/Postnatal Special Interest Group RACGP; Maternity Lead, Brisbane South PHN; Chair, Mater Mother's Hospital Shared Antenatal Care Alignment; Member, Statewide Maternity and Neonatal Clinical Network Steering Committee (Qld)	Provider of MBS funded services reviewed by this Committee
Dr Cara Frame	GP; Antenatal Share Care Provider in private practice (metropolitan) Sydney	Provider of MBS funded services reviewed by this Committee

3.3 Conflicts of interest

All members of the Taskforce, Clinical Committees and Working Groups are asked to declare any conflicts of interest at the start of their involvement and reminded to update their declarations periodically.

4. Areas of responsibility of the Obstetrics Clinical Committee

The following 99 MBS items were identified for review by the Obstetrics Clinical Committee. A full list of items and descriptions are listed in Appendix A.

- Therapeutic procedures: Obstetrics
  - 16399 to 16363 (42 items)
- Therapeutic procedures: Gynaecology
  - 35676 to 35677 (2 items)
- Assistance at caesarean
  - 51306, 51309, 51312 (3 items)
- Diagnostic imaging services: Obstetric ultrasound (in conjunction with the Diagnostic Imaging Clinical Committee)
  - 55700 to 55775 (50 items)
- Diagnostic imaging services: Radiographic examination in connection with pregnancy (in conjunction with the Diagnostic Imaging Clinical Committee)
  - 59503 to 59504 (2 items)
- Pathology services specifically related to pregnancy
  - Not listed as the Pathology Clinical Committee will have primary responsibility for these items.

5. Items to which significant amendments are recommended

5.1 Complex birth item

5.1.1 Issue

Item 16519 covers management of straight-forward labour and delivery (including caesarean section) and item 16522 covers more complex deliveries, with clinical prerequisites listed in the item descriptor. There is concern that a lack of specificity in the descriptor means that the circumstances where item 16522 can be claimed are ambiguous.

The Committee notes that MBS data (Table 3 and Figure 1 below) show there is variation in the number of straight-forward deliveries (item 16519) claimed compared with the number of complex deliveries (item 16522) across the states and territories, that is not explained by clinical factors. The Committee notes that the item descriptor for item 16522 lacks clarity and suggests more specific guidance should be given.

5.1.2 MBS data

Table 3: Services for item 16519 and 16522 by state, 2014–15

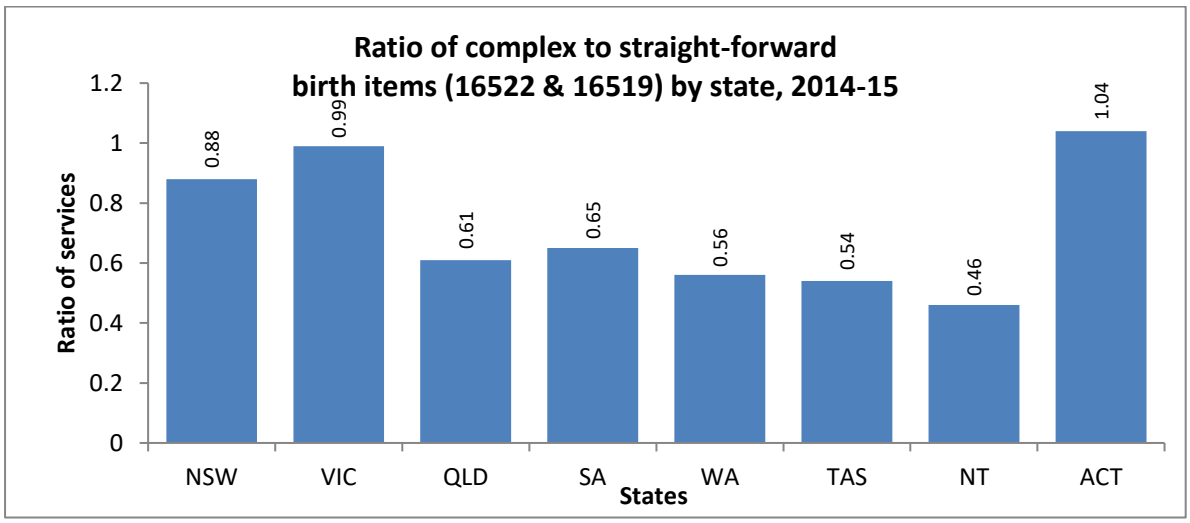
Item	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
16519	14,638	10,167	10,110	3,035	6,942	1,000	502	597	46,991
16522	12,864	10,065	6,099	1,943	3,854	532	228	619	36,204

Source: Department of Human Services, date of processing

Figure 1 shows the ratio of complex deliveries (item 16522) to straight-forward deliveries (item 16519) by state. For example, the ACT has a ratio of 1.04, meaning that for every straight-forward delivery item that is claimed, 1.04 complex delivery items are claimed.

Figure 1 shows that ACT, VIC and NSW had the highest ratio of complex to straight-forward birth items claimed.

Figure 1:Ratio of complex to straight forward birth items (16522 and 16519) by state, 2014–15



Source: Department of Human Services, date of processing

Recommendation 1

The Committee notes that item 16522, with a higher fee than item 16519, was introduced to acknowledge the increased time and additional skill required to manage more complex births. The Committee recommends that item 16522 be amended to include detailed clinical requirements to provide clarity to doctors and to reduce the unexplained variation in claiming patterns. The item cannot be billed unless these requirements are satisfied. The criteria listed in the proposed item have been included based on the clinical judgment of the expert clinicians in the Committee. The Committee also recommends that this item's descriptor is amended to change "delivery" to "birth".

The Committee recommends amendments to item 16522 as follows, with the amended wording underlined:

Current Item Descriptor

MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management one or more of the following conditions is present, including postnatal care for seven days:

- multiple pregnancy;
- recurrent antepartum haemorrhage from 20 weeks gestation;
- grades 2, 3 or 4 placenta praevia;
- baby with a birth weight less than or equal to 2500gm;
- pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring;
- trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery;
- pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mm Hg associated with at least 1+ proteinuria on urinalysis;
- prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress;

- fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR
- conditions that pose a significant risk of maternal death.

Proposed New Item

MANAGEMENT OF LABOUR AND BIRTH, or birth alone, (including caesarean section), on or after 23.0 weeks of gestation, where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days:

- fetal loss;
- multiple pregnancy;
- antepartum haemorrhage of greater than 200 mls or associated with disseminated intravascular coagulation;
- placenta praevia on ultrasound in the third trimester with the placenta within 2cm of the internal cervical os;
- baby with a birth weight less than or equal to 2500gm;
- trial of vaginal birth in a patient with uterine scar where there has been a planned vaginal birth after caesarean section or trial of vaginal breech birth where there has been a planned vaginal breech birth;
- prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress as evidenced by cervical dilatation at less than 1 cm/hr in the active phase of labour (after 3cm cervical dilatation and effacement until full dilatation of the cervix);
- acute fetal compromise evidenced by scalp pH <7.15 OR scalp lactate >4.0 OR one of the following significant cardiotocograph abnormalities: prolonged bradycardia (<100 bpm for >2 minutes), absent baseline variability (<3 bpm), sinusoidal pattern, complicated variable decelerations with reduced (3-5bpm) or absent baseline variability, late decelerations;
- pregnancy induced hypertension of at least 140/90mm Hg associated with at least 2+ proteinuria on urinalysis; OR protein-creatinine ratio of > 30 mg/mmol; OR platelet count < 150 x 109/L; OR uric acid > 0.36 mmol/L;
- gestational diabetes mellitus requiring at least daily blood glucose monitoring;
- mental health disorder (which might arise prior to pregnancy, during pregnancy or postpartum and is demonstrated by the patient requiring hospitalisation and/or having a Mental Health plan; and/or receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder);
- disclosure or evidence of domestic violence;
- any of the following medical conditions either diagnosed prepregnancy or evident at the first antenatal visit before 20 weeks' gestation:
    - pre-existing hypertension requiring antihypertensive medication prior to pregnancy
    - cardiac disease (co-managed with a specialist physician and with echocardiographic evidence of myocardial dysfunction);
    - previous renal or liver transplant; or renal dialysis or chronic liver disease with documented oesophageal varices

- renal insufficiency in early pregnancy (serum creatinine > 110 mmol/L)
- neurological disorder that confines the patient to a wheelchair throughout pregnancy
- maternal height < 148 cm
- a Body Mass Index greater than or equal to 40
- pre-existing diabetes mellitus on medication prior to pregnancy or thyrotoxicosis requiring medication
- previous thrombosis or thromboembolism requiring anticoagulant therapy through pregnancy and the early puerperium
- thrombocytopenia with platelet count < 100,000 prior to 20 weeks' gestation
- HIV or hepatitis B or hepatitis C carrier status positive
- red cell or platelet iso-immunisation
- cancer with metastatic disease
- illicit drug misuse during pregnancy

In hospital service only

5.1.3 Recommendation impact statement

The recommendation to amend item 16522 to include specific criteria will benefit providers as they will have clearer guidance on when this item can be claimed.

5.2 Planning and management of a pregnancy – doctor intends to undertake the birth

5.2.1 Issues

The Committee considered the following issues in relation to this service:

1. Inappropriate claiming: Item 16590 is for the planning and management of a pregnancy where the doctor intends to undertake the birth. MBS data show some medical practitioners are regularly claiming item 16590 when they do not undertake the birth and where they do not provide any other antenatal care to the patient during their pregnancy (see Appendix C for more information).
2. Mental health assessment: The Committee notes that up to 10 per cent of women experience anxiety and/or depression antenatally, increasing to 16 per cent of women experiencing postnatal anxiety and/or depression and that suicide has become one of the leading causes of maternal death in Australia.[ii] The Australian Health Ministers' Advisory Council (AHMAC) endorsed Clinical Practice Guidelines for Antenatal Care[iii] recommends that all pregnant women be screened for perinatal anxiety and depression during pregnancy, and while this is routine practice in public hospitals, there is no structured program for private patients.

3. Requirement to be continuously available: The Committee notes that private obstetricians are required to be continuously available to their patients during their pregnancy and this is not reflected in the item descriptor for 16590.

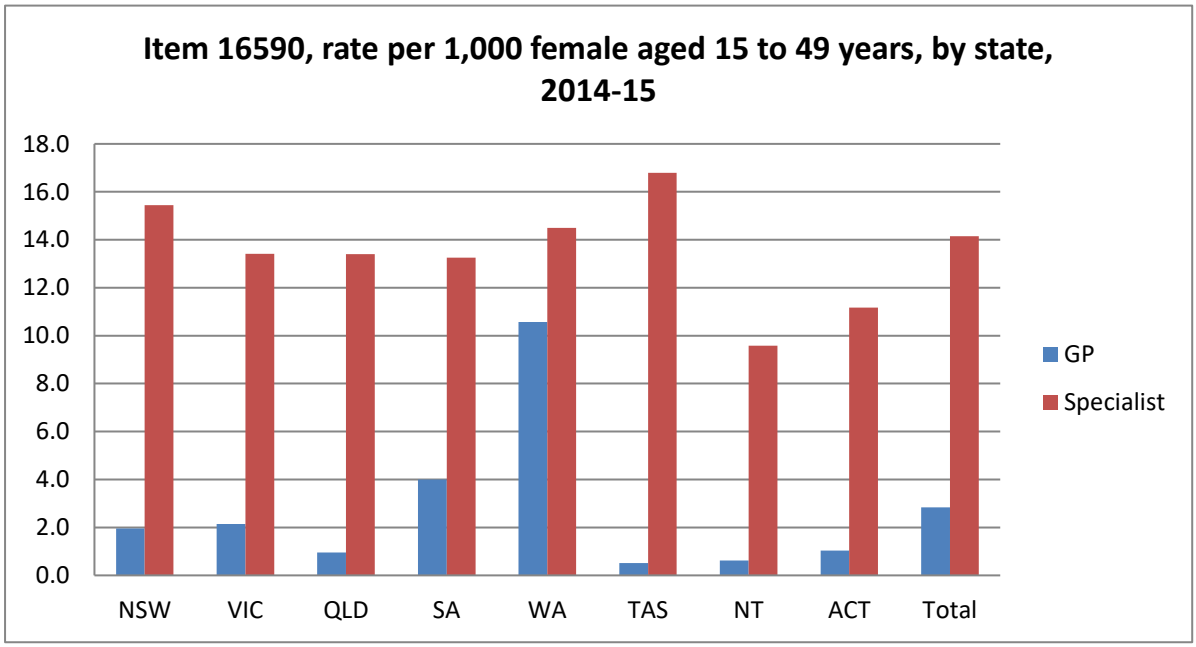
5.2.2 MBS data

Table 4: Services for item 16590 by derived speciality and state, 2014–15

State	GP	Specialist	Total
NSW	3,519	27,811	31,330
VIC	3,124	19,514	22,638
QLD	1,087	15,366	16,454
SA	1,540	5,100	6,640
WA	6,656	9,131	15,787
TAS	56	1,840	1,896
NT	39	599	638
ACT	105	1,133	1,237
Total	16,130	80,496	96,626

Source: Department of Health, unpublished data, date of processing

Figure 2: Item 16590, rate per 1,000 females aged 15-49 by state, 2014-15



Source: Department of Health, unpublished data, date of processing, using ABS population statistics as at 30 June 2015

Figure 2 shows that there is state variation in the rate of services per 1,000 females aged 15-49. Western Australia has a much higher rate of claiming item 16590 by general practitioners than the other states.

A more detailed analysis of MBS data also show some medical practitioners are regularly claiming item 16590 when they do not undertake the delivery and where they do not provide any other antenatal care to the patient during their pregnancy (see Appendix C for more information).

Recommendation 2

The Committee recommends delaying when item 16590 can be claimed from 20 weeks to 28 weeks (so that the model of care is established) and including a requirement that the provider has privileges for intrapartum care in a hospital to clarify the intent of the item for providers and reduce inappropriate claiming. It is expected that the doctor should provide at least 4 antenatal attendances before this item is claimed.

The Committee also recommends that item 16590 include a requirement that a mental health assessment has been performed by the clinician or another suitably qualified health professional and include screening for drug and alcohol use and domestic violence. This will ensure all women are screened for perinatal anxiety and depression (consistent with Australian guidelines), and improve early detection and intervention, improving mental health outcomes for patients.

The Committee recommends that item 16590 include the requirement that the provider is continuously available to the patient during the pregnancy.

The Committee recommends that the fee for item 16590 is increased by 25 per cent to reflect the requirement that the doctor be continuously available during the pregnancy and the requirement of a mental health assessment.

The Committee recommends amendments to item 16590 for planning and management of a pregnancy for privately admitted patients as follows:

Current Item Descriptor

Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and birth, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies.

Proposed new Item descriptor

Changes:

- 20 weeks to 28 weeks
- Remove delivery and add birth

Add:

- Requirement that doctor has privileges for intrapartum care in a hospital or birth centre
- Requirement that a mental health assessment of the patient is performed, including screening for drug and alcohol use and domestic violence (or if already performed by another practitioner, that the results are recorded in the patients' medical record).
- Requirement that doctor is continuously available for the rest of the pregnancy

A patient cannot claim this item and item 16591 for the same pregnancy.

New Fee: $405.15 (25 per cent higher)

5.2.3 Recommendation impact statement

The recommended amendments to item 16590 will benefit patients as there is a requirement that a mental health assessment is undertaken as part of the management of their pregnancy, consistent with clinical practice guidelines.

5.3 Planning and management of pregnancy – provider does not intend to undertake the birth

5.3.1 Issues

The Committee established a GP Antenatal Shared Care Working Group to provide recommendations to the Committee regarding item 16591. The Working Group and Committee found:

1. Inappropriate claiming: Item 16591 is for the planning and management of a pregnancy where the doctor does not intend to undertake the birth, but does take some responsibility for the patient's care (for example through a formal shared care arrangement with a public hospital). The Working Group and Committee notes that MBS data show some medical practitioners are claiming item 16591 when they do not provide any other service to the patient during their pregnancy (see Appendix C for more information).
2. Mental health assessment: The Working Group and Committee note that up to 10 per cent of women experience anxiety and/or depression antenatally, increasing to 16 per cent of women experiencing postnatal anxiety and/or depression and that suicide has become one of the leading causes of maternal death in Australia.[ii] The Australian Health Ministers' Advisory Council (AHMAC) endorsed Clinical Practice Guidelines for Antenatal Care[iii] recommends that all pregnant women be screened by perinatal anxiety and depression during pregnancy.

5.3.2 MBS data

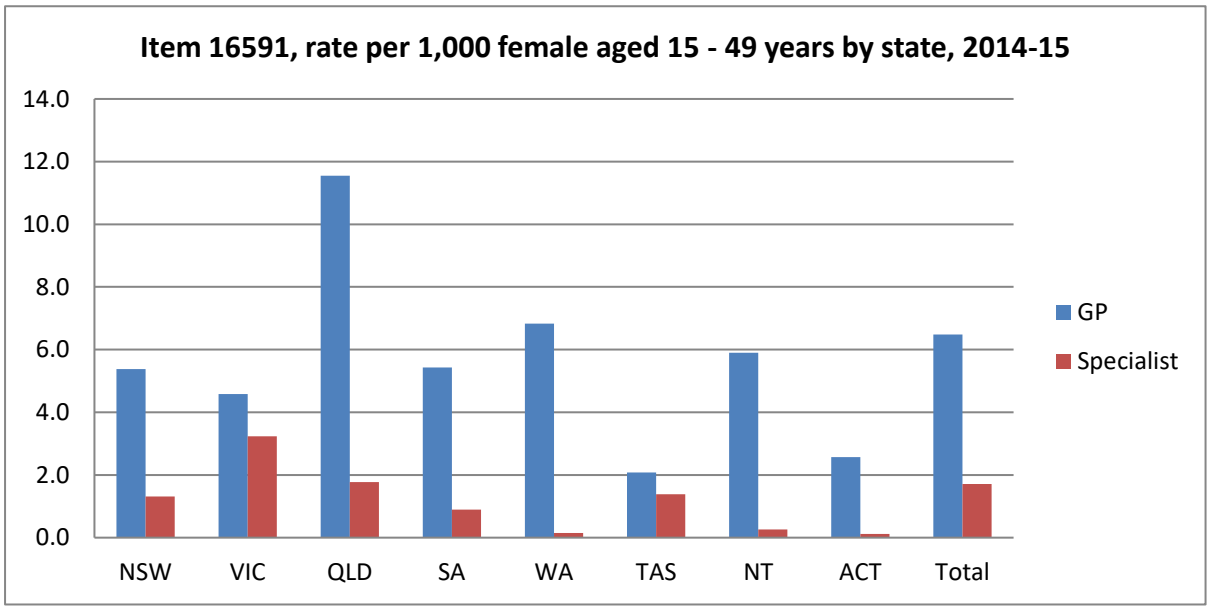
Table 5: Services for item 16591 by derived speciality and state, 2014-15

State	GP	Specialist	Total
NSW	9,689	2,358	12,048
VIC	6,665	4,706	11,371
QLD	13,242	2,030	15,272
SA	2,089	344	2,433
WA	4,302	95	4,397
TAS	228	152	380
NT	369	16	385

State	GP	Specialist	Total
ACT	260	12	272
Total	**36,852**	**9,713**	**46,565**

Source: Department of Health, unpublished data, date of processing.

Figure 3: Item 16591, rate of services per 1,000 females aged 15-49 years by state, 2014-15



Source: Department of Health, unpublished data, date of processing, using ABS population statistics as at 30 June 2015

Figure 3 shows there is state variation in the rate of services per 1,000 females aged 15-49 years. Queensland has a higher rate of claiming item 16591 by general practitioners than the other states, while Victoria has a higher rate of claiming item 16591 by specialists than the other states.

A more detailed analysis of MBS data also show some medical practitioners are regularly claiming item 16591 when they do not do not provide any other antenatal care to the patient during their pregnancy (see Appendix C for more information).

Recommendation 3

The Committee recommends delaying when item 16591 can be claimed from 20 weeks to 28 weeks so that the model of care is established. It is expected that the doctor should provide at least four antenatal attendances before this item is claimed.

The Committee also recommends item 16591 include a requirement that mental health assessment of the patient has been performed by the clinician or another suitably qualified health professional and include a screening for drug and alcohol use and domestic violence. This will ensure all women are screened for perinatal anxiety and depression (consistent with Australian guidelines), and improve early detection and intervention, improving mental health outcomes for patients.

The Committee recommends the following amendments to item 16591 for planning and management of a pregnancy for shared arrangements:

Current Item Descriptor

Planning and management of a pregnancy that has progressed beyond 20 weeks, if the fee does not include any amount for the management of the labour and delivery and, if the care of the patient will be transferred to another medical practitioner, the service is not a service to which item 16590 applies.

Proposed new Item descriptor

Changes:

- Δ 20 weeks to 28 weeks
- Δ Remove delivery and add birth

Add:

- Δ Requirement that a mental health assessment of the patient is performed, including screening for drug and alcohol use and domestic violence (or if already performed by another practitioner, that the results are recorded in the patients' medical record).

A patient cannot claim this item and item 16590 for the same pregnancy.

5.3.3 Recommendation impact statement

The recommended amendments to item 16591 will benefit patients as there is a requirement that a mental health assessment is undertaken as part of the management of their pregnancy, consistent with clinical practice guidelines.

5.4 Management of second trimester labour

5.4.1 Issue

The Committee notes that there is currently one item for management of second trimester labour: item 16525. Management of labour from 24 weeks is currently funded under item 16522 (complex delivery) and management of pregnancy loss prior to 14 weeks is currently funded under item 35643. The Committee notes the low number of services for item 16525 (713 in 2014-15) and that many patients are transferred to the public system for this service. It is the Committee's view that this is undesirable and disrupts continuity of care.

5.4.2 MBS and public hospital data

Table 6: Number of services for item 16525 by state, 2014–15

Item	NSW/ACT	VIC/TAS	QLD	SA/NT	WA	Total
16525	225	265	122	39	36	713

Source: Department of Human Services, date of processing

Table 7: Number of mid trimester deliveries in the public hospital system in 2013–14 by gestational age

14-19 weeks	20-25 weeks
5,104	3,964

Source: Admitted patient care data. 2013–14

Recommendation 4

The Committee recommends that item 16525 is split into two, with the management of early pregnancy loss between 14.0–15.6 weeks gestation retaining the current fee ($384.35), and the management of pregnancy loss between 16 and 22.6 weeks gestation attracting a higher fee ($768.70). This higher fee reflects the additional time and complexity associated with managing late second trimester fetal loss, and the higher risk of maternal complications (for example, retained products, post-partum haemorrhage) and need for extensive patient counselling and support. It is anticipated that fewer patients will be referred to the public system which will improve the continuity of care for these patients.

The Committee recommends that the management of second trimester labour for fetal loss from 23 weeks is claimed under item 16522 (complex delivery). The Committee recommends that management of pregnancy loss before 14 weeks continues to be claimed under item 35643 as currently occurs. The Committee advises that there will be no change in the access of this service for private or public patients as a result of this recommendation.

The Committee has proposed the following changes to item 16525 for second trimester labour:

Current Item 16525 Descriptor and fee

Management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, other than a service to which item 35643 applies (Anaes.)

Fee: $384.35

Proposed amended item 16525 and fee

Management of early pregnancy loss: from 14.0 weeks to 15.6 weeks gestation

Fee: $384.35

Proposed new item and fee

Management of pregnancy loss: from 16.0 weeks to 22.6 weeks gestation

In hospital service only

Fee: $768.70

5.4.3 Recommendation impact statement

The recommendation to replace item 16525 with two new items that cover the management of early and late second trimester fetal loss will benefit patients as they will receive increased MBS rebates for late second trimester services.

5.5 Delivery where the patient is transferred by another medical practitioner

5.5.1 Issue

There are two items for the management of a delivery where the patient has been transferred by another medical practitioner and the doctor undertaking the delivery has not provided any of the antenatal care: items 16515 and 16520. One item is for a vaginal delivery and one item is for a caesarean section. The fee for the caesarean section is $361 higher than for the vaginal delivery. This is in contrast to item 16519 (straight forward delivery) where the fee is the same regardless of whether it is a vaginal delivery or a caesarean section.

5.5.2 MBS data

Table 8: Items 16515 & 16520 - delivery where patient is transferred by another medical practitioner, 2014–15

Item	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
16515	23	25	17	4	9	2	3	0	83
16520	107	59	111	14	133	5	1	9	439

Source: Department of Human Services, date of processing

Recommendation 5

The Committee recommends that items 16515 (vaginal delivery) and 16520 (caesarean section) have the same fee and that it is set in the middle of the current fees for item 16515 and 16520. This change aligns items 16515 and 16520 with the principal birth item (16519) which does not distinguish between a vaginal and operative delivery.

The Committee recommends the following change to the fee for items 16515 and 16520.

Table 9: Current and proposed fee for items 16515 and 16520

Item	Current Item Descriptor	Fee	Proposed fee
16515	Management of vaginal delivery as an independent procedure, if the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.)	$450.65	$630.85

Item	Current Item Descriptor	Fee	Proposed fee
16520	Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.)	$811.05	$630.85

5.5.3 Recommendation impact statement

The recommendation to have the fee for a vaginal delivery and a caesarean section the same if a patient is referred from another medical practitioner will increase the MBS benefits for patients who have a vaginal delivery and reduce the MBS benefits for patients who have a caesarean delivery.

5.6 Delivery where the patient is transferred by participating midwife – Items 16527 and 16528

5.6.1 Issue

There are two items for the management of a delivery where the patient has been transferred by a participating midwife and the doctor undertaking the delivery has not provided any of the antenatal care. One item is for a vaginal delivery and one item is for a caesarean section. The fee for the caesarean section is $361 higher than for the vaginal delivery. This is contrast to item 16519 (straight forward delivery) where the fee is the same regardless of whether it is a vaginal delivery or a caesarean section.

5.6.2 MBS data

Table 10: Item 16527 and 16528 – delivery where patient is transferred by a participating midwife, 2014–15

Item	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	Total
16527	1	0	3	0	0	1	0	1	6
16528	2	0	3	0	1	0	0	0	6

Source: Department of Human Services, date of processing

Recommendation 6

The Committee recommends that items 16527 (vaginal delivery) and 16528 (caesarean section) have the same fee and that it is set in the middle of the current fees for item 16527 and 16528. This change aligns items 16527 and 16528 with the principal birth item (16519) which does not distinguish between a vaginal and operative delivery.

The Committee recommends the following change to the fee for items 16527 and 16528:

Table 11: Current and proposed new items for delivery where patient is transferred by a participating midwife

Item	Current Item Descriptor	Fee	Proposed new fee
16527	Δ Management of vaginal delivery, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery (Anaes.) Δ Payable only once for a pregnancy	$450.65	$630.85
16528	Δ Caesarean section and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth (Anaes.) Δ Payable only once for a pregnancy	$811.05	$630.85

5.6.3 Recommendation impact statement

The recommendation to have the fee for a vaginal delivery and a caesarean section the same if a patient is referred from a participating midwife will increase the MBS benefits for patients who have a vaginal delivery and reduce the MBS benefits for patients who have a caesarean delivery.

6. Recommended new items

6.1 New items equivalent to items 16508 and 16509 where the doctor is required to attend the patient for more than 40 minutes

6.1.1 Issue

The Committee considers that the work involved in providing services covered under item 16508 or item 16509 can be complex and prolonged, particularly in non-urban settings where hospital resources may be more limited. The Committee considers that a hospital attendance to manage these complications that exceeds 40 minutes should attract a higher MBS fee which is equivalent to a GP attendance more than 40 minutes (item 44).

Recommendation 7

The Committee recommends the introduction of two new items equivalent to items 16508 and 16509 with a higher fee, where the attendance is more than 40 minutes, which will more adequately reflect the work involved when treating these pregnancy complications where the attendance is complex and prolonged.

The Committee recommends that the following items for attendances for pregnancy complications over 40 minutes be added to the MBS:

Current item and fee: 16508

Pregnancy complicated by acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day.

Fee: $47.15

Proposed new item and fee: equivalent to item 16508

Add: attendance over 40 minutes, payable once per condition listed per pregnancy

Only claimed in hospital

New Fee: $105.55

Current item and fee: 16509

Preeclampsia, eclampsia or antepartum haemorrhage, treatment of each attendance that is not a routine antenatal attendance

Fee: $47.15

Proposed new item and fee: equivalent to item 16509

Add: attendance over 40 minutes, payable once per condition listed per pregnancy

Only claimed in hospital

New Fee: $105.55

6.1.2 Recommendation impact statement

The recommendation to introduce new items for longer consultations for specific pregnancy complications will benefit patients as they will receive a higher MBS benefit for these services.

6.2 New item for a postnatal consultation

6.2.1 Issue

As discussed earlier, the Committee recommends that all patients have a mental health assessment during pregnancy. The Committee also recommends that all patients have a mental health assessment during the postnatal period, consistent with national guidelines.[iv] Currently, a postnatal attendance after the postnatal care period provided by an obstetrician is claimed under item 16404 – subsequent attendance by an obstetrician. Participating midwives have specific items for postnatal consultations. GPs claim the relevant GP attendance items.

Recommendation 8

The Committee recommends a new item be introduced for a postnatal attendance (usually performed at 6 weeks after birth) which requires obstetricians or GPs, or a suitably qualified health practitioner, to undertake a mental health assessment of the patient, including screening for alcohol and drug use and domestic violence. The Committee considers the current fee for item 16404 (equivalent to a less than 20 minute GP consultation – item 23) to be inadequate to compensate for a mental health assessment in addition to the other requirements of a postnatal attendance by an obstetrician. The Committee considers a fee equivalent to a 20–40 minute consultation by a GP (item 36) is more appropriate for this service.

The Committee recommends that the following item for a postnatal consultation is added to the MBS:

Current Item Descriptor and fee

16404 (Obstetricians currently claim)

Professional Attendance at Consulting Rooms or a Hospital by a Specialist in the Practice of His or Her Specialty of Obstetrics After Referral of the Patient to Him or Her - Each Attendance Subsequent to the First Attendance in a Single Course of Treatment.

Fee: $43.00

GPs currently claim an attendance item (e.g. item 23 or 36)

23 - Professional attendance at consulting rooms – **Fee:** $37.05

36 - Professional attendance at consulting rooms – **Fee:** $71.70

Proposed new MBS item and fee

GPs and obstetricians can claim this item.

Requirement that it take place between 1-8 weeks after birth.

Consultation lasts at least 20 minutes.

Requirement that a mental health assessment of the patient is performed by the clinician or a suitably qualified health practitioner and includes screening of alcohol and drug use and domestic violence.

Payable once only per pregnancy. Available for all public and private patients.

Fee: $71.70

6.2.2 Recommendation impact statement

The recommendation to introduce an item specifically for a postnatal consultation will benefit patients as they will receive a higher MBS fee for this more comprehensive service.

6.3 New item: Postnatal home visit

6.3.1 Issue

The Committee notes that while the majority of women who give birth as a public patient in a public hospital receive at least one home visit in the week or two after birth from a state or local government employed midwife and/or child and maternal health nurse, not all women who have a private obstetricians do. Currently GPs have access to a number of home visit items for all patients and participating midwives have items for postnatal consultations (82130 and 82135) that may be provided in the patient's home.

Recommendation 9

The Committee considers that postnatal support, particularly in the first few weeks after birth, is essential and at least one home visit by a midwife is recommended for all women by numerous states and territories for public patients. This new item will enable private sector patients to access a postnatal service through the MBS. The fee is based on the fee for participating midwives to provide a short postnatal consultation (item 82310), noting that item 82310 can be claimed for a service provided in the consulting rooms or at the patient's home.

Proposed new MBS item and fee

Home visit

Must be performed within 1-3 weeks after birth

Performed by an obstetrician, GP or registered midwife (if midwife, it will be on behalf of, and under the supervision of a medical practitioner)

Only available for patients who were privately admitted for the birth by a GP obstetrician or Obstetrician

Consultation lasts at least 20 minutes

Requirement that a mental health assessment of the patient is performed, and a screening of alcohol and drug use and domestic violence is performed.

Payable once only per pregnancy

Fee: $53.40

6.3.2 Recommendation impact statement

The recommendation to introduce a new item for a postnatal home visit will benefit private patients who do not current have access to state-funded home visits by a midwife.

7. Obstetric services in rural and remote areas

The Committee notes that rural obstetricians and rural GP obstetricians have a higher workload per patient compared with their colleagues in metropolitan areas for a number of reasons:

- Rural maternity units may have few or no junior medical staff with obstetric expertise. This means that the workload for a consultant obstetrician is more demanding and their presence within the hospital is required more frequently and for longer periods.
- Rural maternity units may have fewer resources including critical care services, blood bank, interventional radiology, mental health services and intimate partner violence services and increased patient complexity (associated with lower socioeconomic status) with fewer specialists and subspecialists. Medium levels of complexity are more often managed locally than is the norm in urban practice.

The Committee also notes that the average fees charged by obstetricians and GP obstetricians working in rural areas are markedly less than those in metropolitan areas. However, the need to provide an integrated service that includes managing labour, birth and the early puerperium often with little ancillary support means that, generally, workloads are higher in rural obstetric practice within the same item number.

The Committee agrees that there is a need to support rural obstetrics given the high value the community attaches to accessing maternity services in non-urban Australia. However, the issues identified and their relevance to the MBS Review, are not confined to obstetric practice.

Recommendation 10

The Committee recommends that the MBS Review Taskforce consider how to better support rural service delivery and in particular the role of financial incentives in supporting the provision of MBS funded health services in rural and remote Australia.

8. Items to be removed

8.1 Procedure on multiple pregnancies – Items 16633 and 16636

8.1.1 Issue

Items 16633 and 16636 provide reduced MBS benefits when MBS items for interventional techniques (items 16600 to 16627) are performed on additional fetuses in the case of multiple pregnancies. Table 12 shows the services for items 16633 and 16636 are very low. A full list of the interventional techniques is in Table 13 below.

The derived fee for these items is 50 per cent of the fee for the first fetus for any additional fetus tested. For example, if an amniocentesis (item 16600) is performed on the first fetus, the schedule fee is $63.50. If an amniocentesis is also performed on a second fetus in the case of twins, the schedule fee for that second amniocentesis is half the original schedule fee, $31.75.

Items 16633 and 16636 were introduced as it was considered that there were efficiencies for the provider in performing the same interventional technique twice (or more) for the same patient.

8.1.2 MBS data

Table 12: MBS items for procedure on multiple pregnancies, 2014–15

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
16633	Procedure on multiple pregnancies relating to items 16606, 16609, 16612, 16615 and 16627	Derived fee: 50% of the fee for the first fetus for any additional fetus tested	3
16636	Procedure on multiple pregnancies relating to items 16600, 16603, 16618, 16621 and 16624	Derived fee: 50% of the fee for the first fetus for any additional fetus tested	49

Source: Department of Human Services, date of processing

Table 13: Items for interventional techniques, 2014-15

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
16600	Amniocentesis, Diagnostic.	63.50	3,241
16603	Chorionic Villus Sampling, by Any Route.	121.85	2,014
16606	Fetal Blood Sampling, Using Interventional Techniques From Umbilical Cord or Foetus, Including Fetal Neuromuscular Blockade and Amniocentesis.	243.25	67
16609	Fetal Intravascular Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling.	496.00	33

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
16612	Fetal Intraperitoneal Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling - Not Performed in Conjunction With a Service Described in Item 16609.	390.25	1
16615	Fetal Intraperitoneal Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling - Performed in Conjunction With a Service Described in Item 16609.	207.85	-
16618	Amniocentesis, Therapeutic, When Indicated Because of Polyhydramnios With at Least 500ml Being Aspirated.	207.85	68
16621	Amnioinfusion, for Diagnostic or Therapeutic Purposes in the Presence of Severe Oligohydramnios.	207.85	5
16624	Fetal Fluid Filled Cavity, Drainage of.	299.10	19
16627	Feto-amniotic Shunt, Insertion of, Into Fetal Fluid Filled Cavity, Including Neuromuscular Blockade and Amniocentesis.	608.95	11

Source: Department of Human Services, date of processing

Recommendation 11

The Committee considers that while there may be some efficiencies in performing multiple interventional techniques on a patient that has a multiple pregnancy in terms of patient counselling and consent, the procedures themselves are in fact more complex for the second and additional fetuses, and the fee for the interventional procedures for the additional fetuses should be same as for the first, rather than a reduced fee.

The Committee therefore recommends that items 16633 and 16636 be removed from the MBS. Patients with a multiple pregnancy, who have an interventional technique on all fetuses, will be able to claim the original MBS item (for example 16600 for a diagnostic amniocentesis) for each fetus and receive the full MBS rebate for each fetus.

8.1.3 Recommendation impact statement

Removal of items 16633 and 16636 from the MBS will not have any impact on providers. Patients will receive a higher MBS rebate for the second and subsequent fetus if they claim items 16600 to 16627.

8.2 Removal of ectopic pregnancy item performed by General Practitioners

8.2.1 Issue

There are currently 'differential' MBS items where a different item number and level of benefit are allocated to GPs and Specialists for the same medical service. Specialists attract a higher rebate for

the same service. There are two of these 'differential' MBS items for obstetric services – removal of ectopic pregnancy (items 35676 and 35677).

8.2.2 MBS data

Table 14: Removal of ectopic pregnancy items, schedule fee and services

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
35676	Removal of ectopic pregnancy by a general practitioner	425.00	4
35677	Removal of ectopic pregnancy by a specialist	536.00	20

Source: Department of Human Services, date of processing

Recommendation 12

The Clinical Committee recommends that item 35676 is removed and that item 35677 is amended so that both GPs and Specialists can access this item.

8.2.3 Recommendation impact statement

This recommendation to allow GPs to access item 35677 will benefit patients who have an ectopic pregnancy removed by a GP as they will receive increased MBS rebates for the service.

9. Obsolete Items

9.1 Item 16404

After a review of the items and the associated MBS data, the Committee identified one MBS item as obsolete.

Table 15: Item descriptor, schedule fee and services for item 16504

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
16504	Treatment of habitual miscarriage by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance	47.15	30

Source: Department of Human Services, date of processing

9.1.1 MBS data

Table 16: MBS benefits, services for Item 16504

Item	Schedule fee ($)	Item start date	Benefits paid 2014–15	Number of services (2014–15)	Services from 2009–10 to 2014–15
16504	47.15	1995	1,319	30	566

Source: Department of Human Services, date of processing

Table 17: Services for item 16504 by state, 2014–15

Item	NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
16504	6	5	5	10	1	2	0	1	30

Source: Department of Human Services, date of processing

9.2 Items 59503 and 59504 - Pelvimetry

The Diagnostics and Imaging Clinical Committee identified two pregnancy related diagnostic imaging MBS items that are obsolete, and the Committee agreed that these items are obsolete.

Table 18: Services for items 59503 and 59504 – Pelvimetry

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
59503	Pelvimetry, not being a service associated with CT – pelvimetry	89.40	13
59504	Pelvimetry, not being a service associated with CT – pelvimetry, with aged equipment	$44.70	-

Source: Department of Human Services, date of processing

8.2.1 MBS data

Table 19: MBS benefits, services for item 59503 and 59504

Item	Schedule fee ($)	Item start date	Benefits paid 2014–15	Number of services 2014–15	Services from 2009–10 to 2014–15
59503	89.40	1991	1,109	13	185
59504	44.70	2011	-	-	-

Source: Department of Human Services, date of processing

Recommendation 13

In December 2015, these three items were included in an open public consultation. Comments received were considered by the Committee (and the Diagnostics Imaging Clinical Committee regarding items 59503 and 59504) and in February 2016 the MBS Review Taskforce recommended to Government that these items be removed from the MBS. The Government agreed to this recommendation and these items were removed from the MBS on 1 July 2016.

9.2.1 Recommendation impact statement

Removal of these items from the MBS is not expected to have an impact on providers or patients. Removing obsolete items from the MBS will benefit providers as it will minimise confusion about which item should be claimed for services and will benefit patients as there will be no Medicare benefit for outdated services, thereby incentivising current clinical practice.

10. Minor Changes

10.1 Simplify wording and updating terminology

This first group of items requires amendment to simplify wording and update terminology ('delivery' to 'birth', 'intrauterine growth retardation' to 'intrauterine growth restriction', 'foetus' to 'fetus').

Recommendation 14

Table 20: MBS items that require minor amendment

Item	Current item descriptor	Schedule fee ($)	Services (2014–15)	Proposed amendment
16401	Obstetric Specialist, Referred Consultation - Surgery or Hospital Professional Attendance at Consulting Rooms or a Hospital by a Specialist in the Practice of His or Her Specialty of Obstetrics, After Referral of the Patient to Him or Her - Each Initial Attendance, in a Single Course of Treatment - Not Being a Service to Which Item 104 Applies.	85.55	111,818	Simplify wording with no change to how this item can be claimed.
16404	Professional Attendance at Consulting Rooms or a Hospital by a Specialist in the Practice of His or Her Specialty of Obstetrics After Referral of the Patient to Him or Her - Each Attendance Subsequent to the First Attendance in a Single Course of Treatment.	43.00	94,968	Simplify wording with no change to how this item can be claimed.
16508	Pregnancy complicated by acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital – each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	47.15	1,360	Change 'intrauterine growth retardation' to 'intrauterine growth restriction'

Item	Current item descriptor	Schedule fee ($)	Services (2014–15)	Proposed amendment
16515	Management of vaginal delivery as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery	450.65	83	Change 'delivery' to 'birth'
16518	Management of labour, incomplete, where the patient's care has been transferred to another medical practitioner for the completion of the delivery	450.65	354	Change 'delivery' to 'birth'
16519	Management of labour and delivery (by any means including caesarean section) including post-partum care for 5 days	693.95	46,991	Change 'delivery' to 'birth'
16606	Fetal Blood Sampling, Using Interventional Techniques From Umbilical Cord or Foetus, Including Fetal Neuromuscular Blockade and Amniocentesis.	243.25	67	Change 'foetus' to 'fetus'
51306	Assistance at delivery involving Caesarean section	124.65	25,088	Change 'delivery' to 'birth'
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving a caesarean section	Derived fee: 1/5 of the established fee for the operation or combination of operations	1,713	Change 'delivery' to 'birth'

Source: Department of Human Services, date of processing

10.2 Removing restriction that item 16406 can only be claimed at 32–36 weeks gestation

Table 21: Item 16406 - obstetric visit at 32-36 weeks, schedule fee and services

Item descriptor	Schedule fee ($)	Services (2014–15)
32-36 WEEK OBSTETRIC VISIT Antenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. Payable only once for a pregnancy.	$133.95	2,859

Source: Department of Human Services, date of processing

10.2.1 MBS data

Table 22: Services for item 16406 by state, 2014–15

NSW	VIC	QLD	SA	WA	TAS	ACT	NT	Total
481	236	349	13	1743	2	4	31	2,859

Source: Department of Human Services, date of processing.

10.2.2 Issue

The Committee notes that the current MBS item for a patient to consult an obstetrician when being cared for by a participating midwife is restricted to when the patient is between 32 and 36 weeks gestation. The Committee agrees that this restriction does not encourage collaboration early in the patient's pregnancy. Patients can currently claim item 16401 or 16404 (both which have a lower fee) for an antenatal attendance with an obstetrician if referred by a participating midwife earlier in the pregnancy.

Recommendation 15

Removing the requirement that this item can only be claimed when the patient is 32-36 weeks gestation will ensure that participating midwives are encouraged to collaborate with the obstetrician or GP obstetrician earlier in the pregnancy if clinically appropriate.

The Committee recommends amendments to item 16406 as follows:

Current item description – 16406

32-36 Obstetric visit

Antenatal professional attendance, as part of a single course of treatment, at 32–36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. Payable only once for a pregnancy

Proposed amendments

Remove: “32–36 Obstetric visit” and replace with “Obstetric visit”

Remove: “at 32–36 weeks of the patient’s pregnancy”

10.2.3 Recommendation impact statement

This recommendation to remove the requirement that this item can only be claimed when the patient is 32–36 weeks gestation will benefit patients as they will receive increased MBS rebates if they are referred to an obstetrician earlier in their pregnancy.

11. No Changes

The Committee recommends that the MBS items listed in Table 23 do not require amendment, as they are clinically appropriate.

Table 23: MBS items that do not require amendment

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies	Derived fee: 50% of the fee for item 16401, 16404, 16406, 16500, 16590 or 16591.	74
16500	Antenatal attendance	47.15	1,343,853
16501	External Cephalic Version for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy	140.55	660
16502	Polyhydramnios, unstable lie, multiple pregnancy, pregnancy complicated by diabetes or anaemia, threatened premature labour treated by bed rest only or oral medication, requiring admission to hospital, each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	47.15	6,408

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
16505	Threatened abortion, threatened miscarriage or hyperemesis gravidarum requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	47.15	1,514
16509	Pre-eclampsia, eclampsia or antepartum haemorrhage, treatment of—each attendance that is not a routine antenatal attendance	47.15	4,575
16511	Cervix, Purse String Ligation of (Anaes.)	219.95	437
16512	Cervix, Removal of Purse String Ligature of (Anaes.)	63.50	263
16514	Antenatal cardiotogcography in the management of high risk pregnancy (not during the course of the confinement)	36.65	56,854
16564	Evacuation of retained products of conception (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.)	218	1,117
16567	Management of postpartum haemorrhage by special measures such as packing of uterus, as an independent procedure (Anaes.)	318.80	594
16570	Acute inversion of uterus, vaginal correction of, as an independent procedure (Anaes.)	416.05	15
16571	Cervix, repair of extensive laceration or lacerations (Anaes.)	318.80	23
16573	Third degree tear, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.)	259.80	327
16600	Amniocentesis, Diagnostic.	63.50	3,241
16603	Chorionic Villus Sampling, by Any Route.	121.85	2,014
16609	Fetal Intravascular Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling.	496.00	33
16612	Fetal Intraperitoneal Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade,	390.25	1

Item	Item descriptor	Schedule fee ($)	Services (2014–15)
	Amniocentesis and Fetal Blood Sampling - Not Performed in Conjunction With a Service Described in Item 16609.		
16615	Fetal Intraperitoneal Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling - Performed in Conjunction With a Service Described in Item 16609.	207.85	-
16618	Amniocentesis, Therapeutic, When Indicated Because of Polyhydramnios With at Least 500ml Being Aspirated.	207.85	68
16621	Amnioinfusion, for Diagnostic or Therapeutic Purposes in the Presence of Severe Oligohydramnios.	207.85	5
16624	Fetal Fluid Filled Cavity, Drainage of.	299.10	19
16627	Feto-amniotic Shunt, Insertion of, Into Fetal Fluid Filled Cavity, Including Neuromuscular Blockade and Amniocentesis.	608.95	11

Source: Department of Human Services, date of processing

12. Priority Review

All MBS items will be reviewed during the course of the MBS Review. However, in order to pilot the proposed review methodology, the Taskforce selected a first tranche of Clinical Committees, including obstetrics, and for each committee, selected priority reviews.

Identification of the priority reviews involved a triage process which involved a review of:

- The Choosing Wisely recommendations, both from Australian and internationally.
- National Institute for Health and Care Excellence (NICE UK) Do Not Do recommendations and clinical guidance.
- Other literature on low value care, including Elshaug et al's[i] Medical Journal of Australia article on potentially low value health services.
- The Australian Commission on Quality and Safety in Health Care's (ACQSHC) Atlas of Clinical Variation.

12.1 Prenatal pathology testing

The Taskforce asked the Committee to review prenatal pathology testing as a priority.

12.1.1 Issue

The Committee noted the pathology recommendations in the Australian Health Ministers' Advisory Council (AHMAC) endorsed Clinical Practice Guidelines for Antenatal Care[iii]. The Committee noted that the MBS data showed state variation in the claiming patterns for various pathology MBS items for pregnant women and that some pregnant women appeared not to be receiving some of the recommended pathology tests.

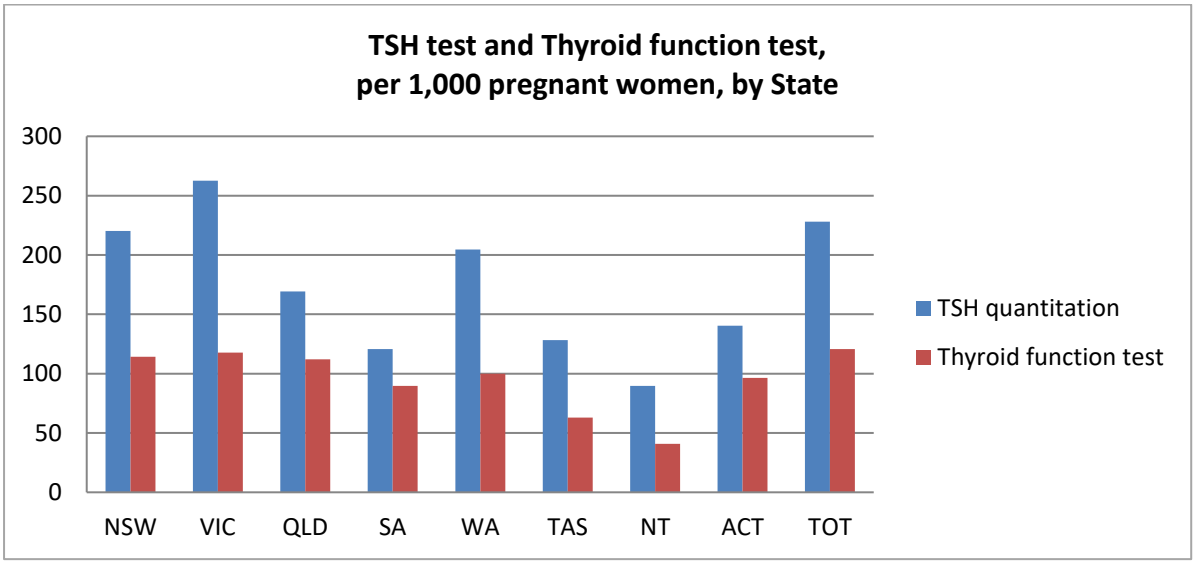
12.1.2 MBS data

The MBS data presented in this section comes from women who underwent an MBS funded 20 week ultrasound in 2013–14, and captures all MBS funded pathology tests claimed by these women in the five months before and after they claimed the 20 week ultrasound.

Note: If a doctor does not advise a pathology laboratory that a woman is pregnant, or does not record that information for billing purposes, it is possible that services provided to pregnant women may be recorded under an incorrect item number.

MBS data showed there was significant state variation in a number of prenatal pathology tests.

Figure 4: State variation in TSH and Thyroid function test items

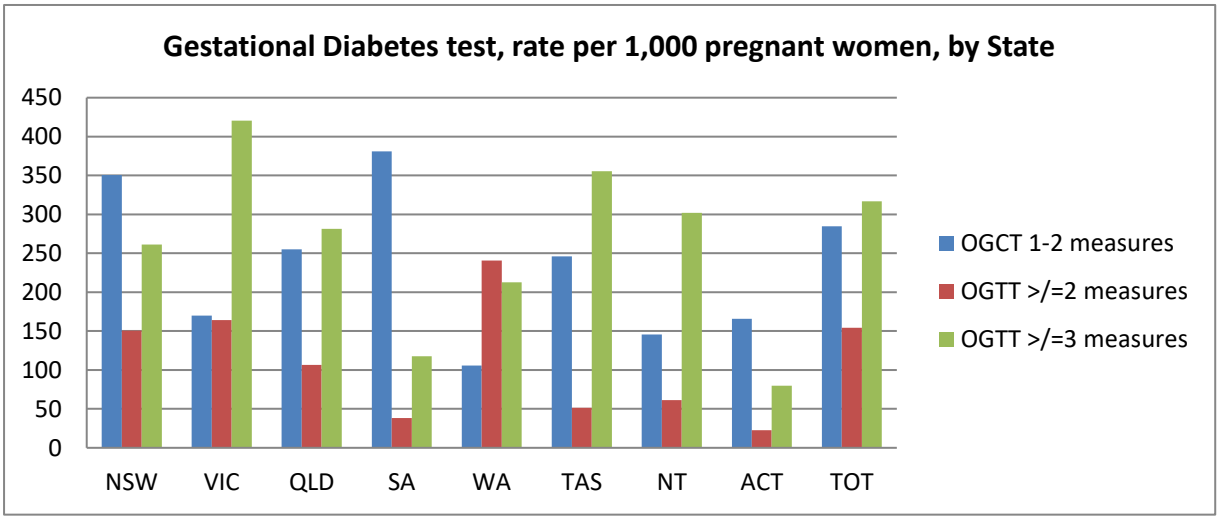


Source: Department of Health, unpublished data, date of service, accessed on 5 August 2015

Thyroid-stimulating hormone (TSH) testing (66716) should only be performed in pregnant women who have symptoms for or are at high risk for thyroid disease. Twenty three per cent of pregnant women had this test performed. VIC, NSW and WA all have rates higher than 200/1000 pregnant women being tested.

Thyroid function tests (66719) should only be performed in the case of an abnormal TSH (using pregnancy normative values as TSH changes with pregnancy). Twelve per cent of Australian pregnant women had this test performed. There is little state to state variation.

Figure 5: State variation in gestational diabetes test



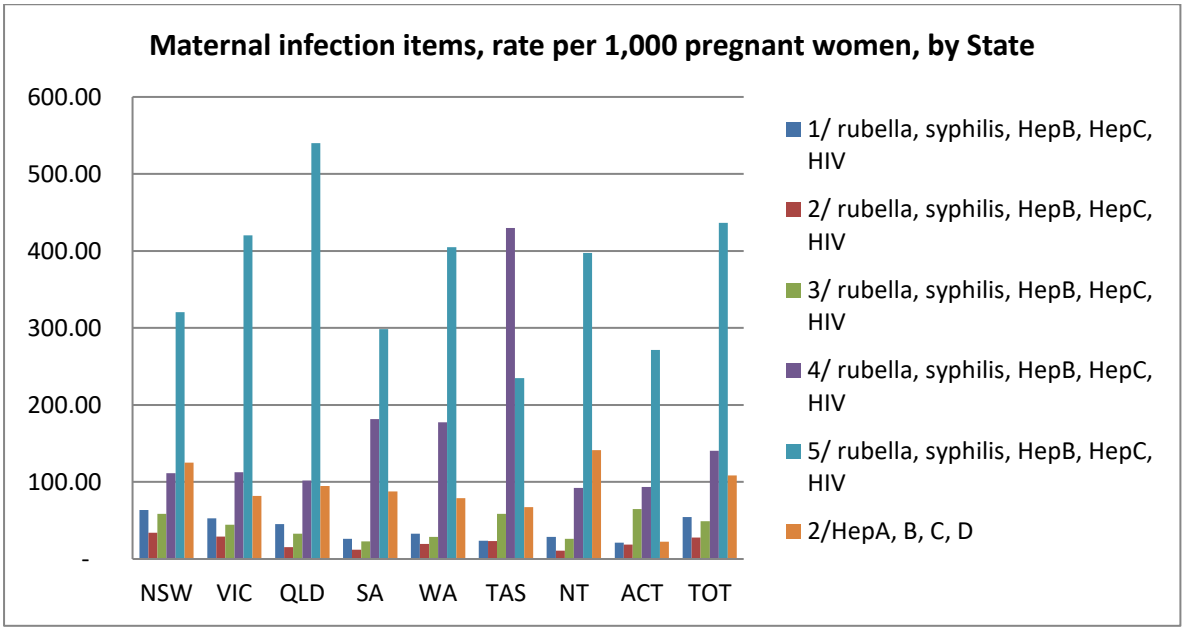
Source: Department of Health, unpublished data, date of service, accessed on 5 August 2015

Note: OGTT = oral glucose tolerance test; OGCT = oral glucose challenge test

Thirty two per cent of pregnant women in Australia received an oral glucose tolerance test (OGTT) (3 measures), twenty eight per cent of pregnant women received an oral glucose challenge test (OGCT) and fifteen per cent received an OGTT (2 measures to diagnose diabetes mellitus).

There is significant state variation in use of these tests. NSW, SA, and the ACT have strong preference for the OGCT. WA was the only state to predominantly use the OGTT >/=2 measures. VIC, QLD, TAS and the NT used the OGTT >/=3 measures predominantly.

Figure 6: State variation in maternal infection items



Source: Department of Health, unpublished data, date of service, accessed on 5 August 2015

More women received 5 tests instead of 4 tests in all states except Tasmania. A strong majority of women from QLD, VIC and the NT received the 5 tests.

Recommendation 16

The Committee agreed that to standardise antenatal pathology screening according to agreed national guidelines and improve health outcomes for pregnant women and their babies, there should be one item that includes all of the basic pathology tests that pregnant women should have done in the first trimester. The tests to be included in this 'panel' are:

- **65070** – Full blood count
- **65096** – Blood grouping and examination of serum for Rh and other blood group antibodies
- **69333** – Urinalysis with MSU mcs
- **69415** – Hepatitis B, Hepatitis C, HIV, rubella, syphilis (item is for testing all five)

As this recommendation relates to pathology MBS items, it has been referred to the Pathology Clinical Committee for consideration and will be released for public consultation later in 2016.

12.2 Pregnancy ultrasounds

The Committee is finalising a number of recommendation regarding pregnancy ultrasounds which will be provided to the Diagnostic Imaging Clinical Committee for consideration.

13. References

This contains references to sources and materials referenced in this report.

i. Elshaug A, et al (2012). Over 150 potentially low-value health care practices: an Australian study. Medical Journal of Australia; Vol.197 (10), 556-560.

ii. AIHW: Humphrey MD, Bonello MR, Chughtai A, Macaldowie A, Harris K & Chambers GM 2015. Maternal deaths in Australia 2008–2012. Maternal deaths series no. 5. Cat. no. PER 70. Canberra: AIHW.

iii. Australian Health Ministers' Advisory Council 2012, *Clinical Practice Guidelines: Antenatal Care – Module 1*. Australian Government Department of Health and Ageing, Canberra. http://www.health.gov.au/antenatal

iv. Austin M-P, Highet N and the Guidelines Expert Advisory Committee (2011) *Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals.* Melbourne: *beyondblue*.

14. Glossary

Term	Description
ACSQHC	The Australian Commission on Safety and Quality in Health Care
ART	Assisted Reproductive Technology
AHMAC	Australian Health Ministers' Advisory Council
Department, The	Australian Government Department of Health
DHS	Australian Government Department of Human Services
GP	General practitioner
High-value care	Services of proven efficacy reflecting current best medical practice, or for which the potential benefit to consumers exceeds the risk and costs.
Inappropriate use / misuse	The use of MBS services for purposes other than those intended. This includes a range of behaviours ranging from failing to adhere to particular item descriptors or rules, through to deliberate fraud.
Low-value care	The use of an intervention which evidence suggests confers no or very little benefit on patients, or that the risk of harm exceeds the likely benefit, or, more broadly, that the added costs of the intervention do not provide proportional added benefits.
MBS item	An administrative object listed in the MBS and used for the purposes of claiming and paying Medicare benefits, comprising an item number, service descriptor and supporting information, Schedule fee and Medicare benefits.
MBS service	The actual medical consultation, procedure, test to which the relevant MBS item refers.
MMM	Monash Modifier Model - is a classification system that categorises metropolitan, regional, rural and remote areas according to both geographical remoteness and population size. The system was developed to recognise the challenges in attracting health workers to more remote and smaller communities.
MSAC	Medical Services Advisory Committee
Multiple operation rule	A rule governing the amount of Medicare benefit payable for multiple operations performed on a patient on the one occasion. In general, the fees for two or more operations are calculated by the following rule: - 100% for the item with the greatest Schedule fee - plus 50% for the item with the next greatest Schedule fee - plus 25% for each other item.
Multiple services rules (diagnostic imaging)	A set of rules governing the amount of Medicare benefit payable for multiple diagnostic imaging services provided to a patient at the same

Term	Description
	attendance (same day). See MBS Explanatory Note DIJ for more information.
NICE	National Institute for Health and Care Excellence
OCC	Obstetrics Clinical Committee
Obsolete services	Services that should no longer be performed as they do not represent current clinical best practice and have been superseded by superior tests or procedures.
Pathology episode coning	An arrangement governing the amount of Medicare benefit payable for multiple pathology services performed in a single patient episode. When more than three pathology services are requested by a general practitioner in a patient episode, the benefits payable are equivalent to the sum of the benefits for the three items with the highest Schedule fees.
PBS	Pharmaceutical Benefits Scheme
PHCAG	Primary Health Care Advisory Group

Appendix A MBS Items considered by the Obstetrics Clinical Committee

Table A1: MBS items considered by the committee – group T4 - Obstetrics

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
16399	Professional attendance on a patient by a specialist practising in his or her specialty of obstetrics if: (a) the attendance is by video conference; and (b) item 16401, 16404, 16406, 16500, 16590 or 16591 applies to the attendance; and (c) the patient is not an admitted patient; and (d) the patient: (i) is located both: (A) within a telehealth eligible area; and (B) at the time of the attendance—at least 15 kms by road from the specialist; or (ii) is a care recipient in a residential care service; or (iii) is a patient of: (A) an Aboriginal Medical Service; or (B) an Aboriginal Community Controlled Health Service for which a direction made under subsection 19 (2) of the Act applies *(See para T4.12 of explanatory notes to this Category)*	50% of the fee for item 16401,16404,16406,16500,16590 or 16591	85% of the derived fee	$24.10
16400	**ANTENATAL CARE** Antenatal service provided by a midwife, nurse or an Aboriginal and Torres Strait Islander health practitioner if: (a) the service is provided on behalf of, and under the supervision of, a medical practitioner; (b) the service is provided at, or from, a practice location in a regional, rural or remote area RRMA 3-7; (c) the service is not performed in conjunction with another antenatal attendance item (same patient, same practitioner on the same day); (d) the service is not provided for an admitted patient of a hospital; and to a maximum of 10 service per pregnancy *(See para T4.1 of explanatory notes to this Category)*	$27.25	85% = $23.20	$11.05
16401	OBSTETRIC SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL	$85.55	75% = $64.20; 85% = $72.75	$54.90

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics, after referral of the patient to him or her - each INITIAL attendance, in a single course of treatment - not being a service to which item 104 applies.			
16404	Professional attendance at consulting rooms or a hospital by a specialist in the practice of his or her specialty of obstetrics after referral of the patient to him or her - each attendance SUBSEQUENT to the first attendance in a single course of treatment.	$43.00	75% = $32.25; 85% = $36.55	$32.95
16406	32-36 WEEK OBSTETRIC VISIT Antenatal professional attendance, as part of a single course of treatment, at 32-36 weeks of the patient's pregnancy when the patient is referred by a participating midwife. Payable only once for a pregnancy.	$133.95	75% = $100.50; 85% = $113.90	$108.15
16500	ANTENATAL ATTENDANCE – *(See para T4.3 of explanatory notes to this Category)*	$47.15	75% = $35.40; 85% = $40.10	$32.95
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy *(See para T4.4 of explanatory notes to this Category)*	$140.55	75% = $105.45;85% = $119.50	$65.90
16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospitaleach attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$47.15	75% = $35.40; 85% = $40.10	$22.00
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance	$47.15	75% = $35.40; 85% = $40.10	$22.00
16508	PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day	$47.15	75% = $35.40; 85% = $40.10	$22.00

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
16509	PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance	$47.15	75% = $35.40; 85% = $40.10	$22.00
16511	CERVIX, purse string ligation of (Anaes.)	$219.95	75% = $165.00; 85% = $187.00	$109.75
16512	CERVIX, removal of purse string ligature of (Anaes.)	$63.50	75% = $47.65; 85% = $54.00	$32.95
16514	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement)	$36.65	75% = $27.50; 85% = $31.20	$16.55
16515	**MANAGEMENT OF LABOUR AND DELIVERY –** MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.) *(See para T4.5 of explanatory notes to this Category)*	$450.65	75% = $338.00; 85% = $383.10	$175.60
16518	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.) *(See para T4.5 of explanatory notes to this Category)*	$450.65	75% = $338.00; 85% = $383.10	$175.60
16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) *(See para T4.5 of explanatory notes to this Category)*	$693.95	75% = $520.50; 85% = $614.45	$329.15
16520	CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) *(See para T4.6 of explanatory notes to this Category)*	$811.05	75% = $608.30; 85% = $731.55	$329.15
16522	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: - multiple pregnancy; - recurrent antepartum haemorrhage from 20 weeks gestation; - grades 2, 3 or 4 placenta praevia; - baby with a birth weight less than or equal to 2500gm; - pre-existing diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood glucose monitoring;	$1,629.35	75% = $1,222.05; 85% = $1,549.85	$438.90

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	- trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; - pre-existing hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least - 140/90mm Hg associated with at least 1+ proteinuria on urinalysis; - prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; - fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR - conditions that pose a significant risk of maternal death. (Anaes.) *(See para T4.7 of explanatory notes to this Category)*			
16525	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.) *(See para T4.5 of explanatory notes to this Category)*	$384.35	75% = $288.30; 85% = $326.70	$153.70
16527	MANAGEMENT OF VAGINAL DELIVERY, if the patient's care has been transferred by a participating midwife for management of the delivery, including all attendances related to the delivery. Payable once only for a pregnancy. (Anaes.) *(See para T4.8 of explanatory notes to this Category)*	$450.65	75% = $338.00; 85% = $383.10	$175.60
16528	CAESAREAN SECTION and post-operative care for 7 days, if the patient's care has been transferred by a participating midwife for management of the birth. Payable once only for a pregnancy. (Anaes.) *(See para T4.8 of explanatory notes to this Category)*	$811.05	75% = $608.30; 85% = $731.55	$329.15
16564	**POST-PARTUM CARE –** EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)*	$218.00	75% = $163.50; 85% = $185.30	$219.45
16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)*	$318.80	75% = $239.10; 85% = $271.00	$219.45
16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)*	$416.05	75% = $312.05; 85% = $353.65	$219.45
16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) *(See para T4.10 of explanatory notes to this Category)*	$318.80	75% = $239.10; 85% = $271.00	$219.45

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) *(See para T4.10 of explanatory notes to this Category)*	$259.80	75% = $194.85; 85% = $220.85	$219.45
16590	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery, payable once only for any pregnancy that has progressed beyond 20 weeks where the practitioner intends to undertake the delivery for a privately admitted patient, not being a service to which item 16591 applies.	$324.10	75% = $243.10; 85% = $275.50	$219.45
16591	Planning and management of a pregnancy that has progressed beyond 20 weeks provided the fee does not include any amount for the management of the labour and delivery if the care of the patient will be transferred to another medical practitioner, payable once only for any pregnancy that has progressed beyond 20 weeks, not being a service to which item 16590 applies.	$142.65	75% = $107.00; 85% = $121.30	$109.75
16600	**INTERVENTIONAL TECHNIQUES –** AMNIOCENTESIS, diagnostic *(See para T4.11 of explanatory notes to this Category)*	$63.50	75% = $47.65; 85% = $54.00	$32.95
16603	CHORIONIC VILLUS SAMPLING, by any route *(See para T4.11 of explanatory notes to this Category)*	$121.85	75% = $91.40; 85% = $103.60	$65.90
16606	FOETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or foetus, including foetal neuromuscular blockade and amniocentesis (Anaes.) *(See para T4.11 of explanatory notes to this Category)*	$243.25	75% = $182.45; 85% = $206.80	$131.75
16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes.) *(See para T4.11 of explanatory notes to this Category)*	$496.00	75% = $372.00; 85% = $421.60	$252.40
16612	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.11 of explanatory notes to this Category)*	$390.25	75% = $292.70; 85% = $331.75	
16615	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) *(See para T4.11 of explanatory notes to this Category)*	**:** $207.85	75% = $155.90; 85% = $176.70	
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated *(See para T4.11 of explanatory notes to this Category)*	$207.85	75% = $155.90; 85% = $176.70	$104.30

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios *(See para T4.11 of explanatory notes to this Category)*	$207.85	75% = $155.90; 85% = $176.70	
16624	FOETAL FLUID FILLED CAVITY, drainage of *(See para T4.11 of explanatory notes to this Category)*	$299.10	75% = $224.35; 85% = $254.25	$142.65
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis *(See para T4.11 of explanatory notes to this Category)*	$608.95	75% = $456.75; 85% = $529.45	$307.25
16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606, 16609, 16612, 16615 and 16627 *(See para T4.11 of explanatory notes to this Category)*	Derived: 50% of the fee for the first foetus for any additional foetus tested		$230.50
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600, 16603, 16618, 16621 and 16624 *(See para T4.11 of explanatory notes to this Category)*	**Derived:** 50% of the fee for the first foetus for any additional foetus tested		$87.85
35676 G	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)	$425.00	75% = $318.75	
35677 S	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)	$536.00	75% = $402.00	
51306	Assistance at a delivery involving Caesarean section (See para T9.1 of explanatory notes to this Category)	$124.65	75% = $93.50; 85% = $106.00	
51309	Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section (See para T9.1 and T9.4 of explanatory notes to this Category)	Derived: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)		

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
51312	Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 (See para T9.1 of explanatory notes to this Category)	Derived: one fifth of the established fee for the procedure or combination of procedures		

Table A2: MBS items considered by the committee – subgroup 5 – obstetric and gynaecological

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
55700	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, if: a) the patient is referred by a medical practitioner or participating midwife; and b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and e) if the patient is referred by a participating midwife - the referring midwife does not have a business or financial arrangement with the providing practitioner; and f) 1 or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55700 or item 55707, not both items. *(See para DIQ of explanatory notes to this Category)*	$60.00	75% = $45.00; 85% = $51.00	$32.95

Table A3: MBS items considered by the committee – ultrasound obstetric and gynaecological

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
55701	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 or 55714 (R) (NK). Fee is payable only for item 55700 or 55701, or, or item 55707 or 55714, not both items *(See para DIQ of explanatory notes to this Category)*	$30.00	75% = $22.50; 85% = $25.50	$16.50
55702	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where:	$17.50	75% = $13.15; 85% = $14.90	$8.30

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 or 55716 (R) (NK). Fee is payable only for item 55702 or 55703, or, item 55707 or 55714, not both items *(See para DIQ of explanatory notes to this Category)*			
55703	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and	$35.00	75% = $26.25; 85% = $29.75	$16.55

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(d) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55703 or item 55707, not both items. *(See para DIQ of explanatory notes to this Category)*			
55704	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, if: (a) the patient is referred by a medical practitioner or participating midwife; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner -- the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and	$70.00	75% = $52.50; 85% = $59.50	$38.50

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(e) if the patient is referred by a participating midwife -- the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55707 (R). Fee is payable only for item 55704 or item 55707, not both items. *(See para DIQ of explanatory notes to this Category)*			
55705	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and	$35.00	75% = $26.25; 85% = $29.75	$16.55

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item number 55708 (R). Fee is payable only for item 55705 or item 55708, not both items. *(See para DIQ of explanatory notes to this Category)*			
55707	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, if; (a) the patient is referred by a medical practitioner or participating midwife; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and	$70.00	75% = $52.50; 85% = $59.50	$38.50

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) if the patient is referred by a medical practitioner – the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) if the patient is referred by a participating midwife – the referring midwife does not have a business or financial arrangement with the providing practitioner; and (f) at least 1 condition mentioned in paragraph (f) of item 55704 is present; and (g) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (h) the service is not performed with item 55700, 55703, 55704 or 55705 on the same patient within 24 hours (R) *(See para DIQ of explanatory notes to this Category)*			
55709	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 (NR) *(See para DIQ of explanatory notes to this Category)*	$38.00	75% = $28.50; 85% = $32.30	$22.00
55710	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the following conditions are present: (i) hyperemesis gravidarum; (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease;	$35.00	75% = $26.25; 85% = $29.75	$19.30

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass; (xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (R) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55704 or 55707 (R) (NK). Fee is payable only for item 55704 or 55710, or, item 55707 or 55714, not both items *(See para DIQ of explanatory notes to this Category)*			
55711	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the following conditions are present: (i) hyperemesis gravidarum (ii) diabetes mellitus; (iii) hypertension; (iv) toxaemia of pregnancy; (v) liver or renal disease; (vi) autoimmune disease; (vii) cardiac disease; (viii) alloimmunisation; (ix) maternal infection; (x) inflammatory bowel disease; (xi) bowel stoma; (xii) abdominal wall scarring; (xiii) previous spinal or pelvic trauma or disease; (xiv) drug dependency; (xv) thrombophilia; (xvi) significant maternal obesity; (xvii) advanced maternal age; (xviii) abdominal pain or mass;	$17.50	75% = $13.15; 85% = $14.90	$8.30

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(xix) uncertain dates; (xx) high risk pregnancy; (xxi) previous post dates delivery; (xxii) previous caesarean section; (xxiii) poor obstetric history; (xxiv) suspicion of ectopic pregnancy; (xxv) risk of miscarriage; (xxvi) diminished symptoms of pregnancy; (xxvii) suspected or known cervical incompetence; (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction; (xxx) risk of fetal abnormality (NR) Footnote: For nuchal translucency measurements performed when the pregnancy is dated by a crown rump length of 45 to 84mm, refer to item 55708 or 55716 (R) (NK). Fee is payable only for item 55705 or 55711, or, item 55708 or 55716, not both items *(See para DIQ of explanatory notes to this Category)*			
55712	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (R) *(See para DIQ of explanatory notes to this Category)*	$115.00	75% = $86.25; 85% = $97.75	$65.90
55713	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) the dating for the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55709 or 55717 (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$50.00	75% = $37.50; 85% = $42.50	$27.50

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
55714	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) one or more of the conditions mentioned in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and (f) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (g) the service is not performed with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$35.00	75% = $26.25; 85% = $29.75	$19.30
55715	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706 or 55709 applies (NR) *(See para DIQ of explanatory notes to this Category)*	$40.00	75% = $30.00; 85% = $34.00	$22.00
55716	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where; (a) the patient is not referred by a medical practitioner; and (b) the pregnancy (as confirmed by ultrasound) is dated by a crown rump length of 45 to 84mm; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) one or more of the conditions in subparagraphs (e) (i) to (xxx) of item 55704 or 55710 are present; and (e) nuchal translucency measurement is performed to assess the risk of fetal abnormality; and (f) the service is not performed in conjunction with item 55700, 55701, 55702, 55703, 55704, 55705, 55710 or 55711 on the same patient within 24 hours (NR) (NK) *(See para DIQ of explanatory notes to this Category)*	$17.50	75% = $13.15; 85% = $14.90	$8.30
55717	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and	$19.00	75% = $14.25; 85% = $16.15	$11.05

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55706 or 55713 (NR) (NK) *(See para DIQ of explanatory notes to this Category)*			
55719	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$57.50	75% = $43.15; 85% = $48.90	$32.95
55720	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55706, 55709, 55713 or 55717 applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)*	$20.00	75% = $15.00; 85% = $17.00	$11.05
55721	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and	$115.00	75% = $86.25; 85% = $97.75	$65.90

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) *(See para DIQ of explanatory notes to this Category)*			
55722	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) the service is not performed in the same pregnancy as item 55723 or 55726; and (f) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma;	$50.00	75% = $37.50; 85% = $42.50	$27.50

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (R) (NK) *(See para DIQ of explanatory notes to this Category)*			
55723	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55718; and (e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma;	$38.00	75% = $28.50; 85% = $32.30	$22.00

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (NR) *(See para DIQ of explanatory notes to this Category)*			
55724	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where: (a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has qualifications recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as being equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (e) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (R) NK) *(See para DIQ of explanatory notes to this Category)*	$57.50	75% = $43.15; 85% = $48.90	$32.95
55725	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (NR) *(See para DIQ of explanatory notes to this Category)*	$40.00	75% = $30.00; 85% = $34.00	$22.00
55726	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) the service is not performed in the same pregnancy as item 55718 or 55722; and (e) one or more of the following conditions are present: (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan);	$19.00	75% = $14.25; 85% = $16.15	$11.05

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxaemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (NR) (NK) *(See para DIQ of explanatory notes to this Category)*			
55727	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (d) further examination is clinically indicated in the same pregnancy to which item 55718, 55722, 55723 or 55726 applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)*	$20.00	75% = $15.00; 85% = $17.00	: $11.05

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
55729	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (R) *(See para DIQ of explanatory notes to this Category)*	$27.25	75% = $20.45; 85% = $23.20	$16.55
55730	Duplex scanning involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of the umbilical artery, and measured assessment of amniotic fluid volume after the 24th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$13.65	75% = $10.25; 85% = $11.65	$8.30
55735	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$63.50	75% = $47.65; 85% = $54.00	
55736	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and (d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R) *(See para DIQ of explanatory notes to this Category)*	$127.00	75% = $95.25; 85% = $107.95	
55737	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR) (NK) *(See para DIQ of explanatory notes to this Category)*	$28.50	75% = $21.40; 85% = $24.25	
55739	PELVIS, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and (b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)	$57.00	75% = $42.75; 85% = $48.45	

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(See para DIQ of explanatory notes to this Category)			
55759	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55762 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)*	$150.00	75% = $112.50; 85% = $127.50	
55760	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 57721, 55762 or 55763 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$75.00	75% = $56.25; 85% = $63.75	
55762	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55715 or 55759during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) *(See para DIQ of explanatory notes to this Category)*	$60.00	75% = $45.00; 85% = $51.00	$32.95
55763	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and	$30.00	75% = $22.50; 85% = $25.50	$16.50

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719, 55720, 55759 or 55760 during the same pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)*			
55764	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759 or 55762 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)*	$160.00	75% = $120.00; 85% = $136.00	$87.85
55765	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, where: (a) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and (e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and (f) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and (g) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$80.00	75% = $60.00; 85% = $68.00	$44.00

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
55766	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, or 55762 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712 or 55715 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)*	$65.00	75% = $48.75; 85% = $55.25	$32.95
55767	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, with measurement of all parameters for dating purposes, performed by or on behalf of a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) the patient is not referred by a medical practitioner; and (b) ultrasound of the same pregnancy confirms a multiple pregnancy; and (c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks of gestation; and (d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; (e) further examination is clinically indicated in the same pregnancy to which item 55759, 55760, 55762 or 55763 has been performed; and (f) not performed in conjunction with item 55706, 55709, 55712, 55713, 55715, 55717, 55719 or 55720 during the same pregnancy (NR) (NK) *(See para DIQ of explanatory notes to this Category)*	$32.50	75% = $24.40; 85% = $27.65	$16.50
55768	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)*	$150.00	75% = $112.50; 85% = $127.50	$82.40
55769	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where: (a) dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and	$75.00	75% = $56.25; 85% = $63.75	$41.25

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner; and (d) the service is not performed in the same pregnancy as item 55770 or 55771; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)*			
55770	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)*	$60.00	75% = $45.00; 85% = $51.00	$32.95
55771	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy), by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) the service is not performed in the same pregnancy as item 55768 or 55759; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55723, 55724,,55725, 55726 or 55727 during the same pregnancy (NR) (NK) *(See para DIQ of explanatory notes to this Category)*	$30.00	75% = $22.50; 85% = $25.50	$16.50
55772	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and	$160.00	75% = $120.00; 85% = $136.00	$87.85

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55723 or 55725 during the same pregnancy (R) *(See para DIQ of explanatory notes to this Category)*			
55773	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has a qualification recognised by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists as equivalent to a Diploma of obstetrics or has obstetric privileges at a non-metropolitan hospital; and (c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 55771 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (g) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (R) (NK) *(See para DIQ of explanatory notes to this Category)*	$80.00	75% = $60.00; 85% = $68.00	$44.00
55774	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where: (a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed ;and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721 55723 or 55725 during the same pregnancy (NR) *(See para DIQ of explanatory notes to this Category)*	$65.00	75% = $48.75; 85% = $55.25	$38.50
55775	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, performed by or on behalf of a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where:	$32.50	75% = $24.40; 85% = $27.65	$19.30

Item	Description	Fee	Benefit	Extended Medicare Safety Net Cap
	(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and (b) the patient is not referred by a medical practitioner; and (c) further examination is clinically indicated in the same pregnancy to which item 55768, 55769, 55770 or 5571 has been performed; and (d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and (e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and (f) the service is not performed in conjunction with item 55718, 55721, 55722, 55723, 55724, 55725, 55726 or 55727 during the same pregnancy (NR) (NK) *(See para DIQ of explanatory notes to this Category)*			

Appendix B Summary for consumers

Obstetrics Clinical Committee recommendations

Recommendation 1: Complex delivery				
Item	**What it does**	**Committee recommendation**	**What would be different**	**Why**
16522	Item 16519 covers the management of straight-forward labour and delivery (including caesarean section) and item 16522 covers more complex deliveries, for example, where the baby has a low birth weight (less than 2.5kg), where it is a twin or higher order multiple pregnancy, or where the patient has diabetes or gestational diabetes that requires daily blood glucose monitoring.	The list of criteria for claiming the complex delivery item is not clear, and more specific guidance should be included in the item.	The proposed item descriptor includes more specific clinical criteria.	These changes will provide clarity to doctors so that they know when this item can be claimed.

Recommendation 2: Planning and management of a pregnancy where the doctor intends to undertake the delivery				
Item	**What it does**	**Committee recommendation**	**What would be different**	**Why**
16590	Item 16590 is for the planning and management of a pregnancy where the doctor intends to undertake the delivery.	To make it more clear that this item can only be claimed by the doctor who is managing the pregnancy, and who intends to undertake the delivery.	The changes will delay when this item can be claimed from 20 weeks to 28 weeks gestation, require that a mental health assessment of the patient is undertaken, and that the doctor has privileges for intrapartum care in a hospital or birth centre. This will benefit patients as there is a requirement that a mental health assessment is undertaken as part of the management of their pregnancy, consistent with clinical practice guidelines.	These changes will reduce inappropriate claiming of item 16590 by providers who are not providing antenatal care to their patients or intending to undertake the delivery. These changes will also increase the number of patients that have a mental health assessment during their pregnancy by making it a requirement of this item.

Recommendation 3: Planning and management of a pregnancy where the doctor does not intend to undertake the delivery				
Item	**What it does**	**Committee recommendation**	**What would be different**	**Why**
16591	Item 16591 is for the planning and management of a pregnancy where the doctor is providing shared antenatal care and is not intending to undertake the delivery.	To ensure all patients have a mental health assessment by making it a requirement of this item.	The changes will delay when this item can be claimed from 20 weeks to 28 weeks gestation, and require that a mental health assessment of the patient is undertaken. This will benefit patients as there is a requirement that a mental health assessment is undertaken as part of the management of their pregnancy, consistent with clinical practice guidelines.	These changes will reduce inappropriate claiming of item 16591 by providers who are not providing antenatal care to their patients and increase the number of patients that have a mental health assessment during their pregnancy by making it a requirement of this item.

Recommendation 4: Management of second trimester labour				
Item	**What it does**	**Committee recommendation**	**What would be different**	**Why**
16525 and New item	Item 16525 is for the management of labour that occurs in the second trimester (between approximately 14 and 23 weeks gestation).	To split this item in two, one for the management of labour between 14 and 16 weeks gestation, and one for the management of labour between 16 and 23 weeks gestation, and to double the fee for the second item.	Item 16525 will be for management of second trimester labour between 14 and 16 weeks gestation. A new item will be introduced for the management of second trimester labour between 16 and 22 weeks gestation. Management of labour from 23 weeks will be covered under item 16522 – complex delivery. This will benefit patients as they will receive increased MBS rebates for late second trimester services.	The fee for managing a second trimester labour is too low for those that take place from 16 weeks onwards. These labours are more complex to manage. It is anticipated that fewer patients will be referred to the public system which will improve the continuity of care for these patients as they will be cared for by a doctor who they know and trust.

Recommendation 5: Management of delivery where the patient is transferred by another medical practitioner

Item	What it does	Committee recommendation	What would be different	Why
16515 and 16520	Item 16515 is for the management of vaginal delivery where the patient has been transferred by another doctor. This may occur if the labour becomes more complex and a more experienced obstetrician is required to safely delivery the baby. Item 16520 is for the management of a caesarean section where the patient has been transferred by another medical practitioner.	Items 16515 and 16520 have the same fee that is set in the middle of the current fees for item 16515 and 16520.	The items would remain the same, the fee of item 16515 would be increased from $450.65 to $630.85, and the fee for item 16520 would be reduced from $811.05 to $630.85. This will increase the MBS benefits for patients who have a vaginal delivery and reduce the MBS benefits for patients who have a caesarean delivery where the delivery is transferred to another doctor. It will benefit patients by eliminating any financial incentive for doctors to perform a caesarean section rather than a vaginal delivery.	The Committee is concerned that having a higher fee for a caesarean section appears to provide a financial incentive for doctors to perform a caesarean rather than a vaginal delivery. This change will make the fees for these items consistent with the item for a straight forward delivery (item 16519) where a vaginal delivery and a caesarean section have the same schedule fee.

Recommendation 6: Management of delivery where the patient is transferred by a participating midwife

Item	What it does	Committee recommendation	What would be different	Why
16527 and 16528	Item 16527 is for the management of vaginal delivery where the patient has been transferred by a participating midwife (private patients only). This may occur if the labour becomes more complex and an obstetrician is required to safely deliver the baby. Item 16520 is for the management of a caesarean section where the patient has been transferred by a participating midwife.	Items 16527 and 16528 have the same fee that is set in the middle of the current fees for item 16527 and 16528.	The items would remain the same, the fee of item 16527 would be increased from $450.65 to $630.85, and the fee for item 16528 would be reduced from $811.05 to $630.85. This will increase the MBS benefits for patients who have a vaginal delivery and reduce the MBS benefits for patients who have a caesarean delivery where the delivery is transferred to a doctor by a participating midwife. It will benefit patients by eliminating any financial incentive for doctors to perform a caesarean section rather than a vaginal delivery.	The Committee is concerned that having a higher fee for a caesarean section appears to provide a financial incentive for doctors to perform a caesarean rather than a vaginal delivery. This change will make the fees for these items consistent with the item for a straight forward delivery (item 16519) where a vaginal delivery and a caesarean section have the same schedule fee.

Recommendation 7: New items for consultations longer than 40 minutes for selected pregnancy complications				
Item	**What it does**	**Committee recommendation**	**What would be different**	**Why**
New items	Item 16508 is for consultations with a doctor where there are pregnancy complications such as threatened premature labour where the patient's waters have broken, which requires the patient to go to hospital for treatment. Item 16509 is for consultations with a doctor where there are pregnancy complications such as preeclampsia.	Introduce new items that are the same as items 16508 and 16509 but where the attendance is complex enough that the doctor was required to care for the patient for more than 40 minutes. These new items have higher fees.	The new items would be the same as the current items for 16508 and 16509 but would require that the doctor has cared for the patient for at least 40 minutes. This will benefit patients as they will receive a higher MBS benefit for the longer consultations.	The Committee notes that some patients require longer care than others for these pregnancy complications, particularly in more rural hospitals where there aren't other doctors and nurses to help care for the patient. New items with higher fees where the doctor must provide care for the patient for more than 40 minutes will reflect this extra work.

Recommendation 8: New item for postnatal check-up				
Item	**What it does**	**Committee recommendation**	**What would be different**	**Why**
New item	All patients should have a check-up with their doctor after birth. This usually occurs at 6 weeks after birth. Item 16404, which is for a subsequent consultation with an obstetrician, is currently used when the obstetrician has a consultation with a patient after the birth.	A new item is introduced to specifically cover a postnatal check-up of a patient between 1 and 8 weeks after birth.	The new item specifies that a mental health assessment of the patient must be performed, along with the other routine postnatal checks that occur at this item. The fee for this item will be higher than item 16404, and will be equivalent to a 20 minute consultation with a general practitioner ($71.70) This will benefit patients as they will receive a higher MBS fee for this more comprehensive service, which will now include a mental health assessment.	The Committee thinks that the current fee for item 16404 is not high enough when the requirement of a mental health assessment is included, in addition to the other requirements of a postnatal check-up. This item will increase the number of women having a mental health assessment within 8 weeks of birth by making it a requirement of this item.

Recommendation 9: New item for home visit between 1 and 3 weeks after delivery

Item	What it does	Committee recommendation	What would be different	Why
New item	Home visits in the first few weeks after birth for public patients can involve giving the baby a development check, providing advice on feeding and settling, and a mental health assessment of the mother.	A new item is introduced for a home visit by a GP, obstetrician, or registered nurse (who works under the supervision of a GP or obstetrician), between 1 and 3 weeks after birth.	There are no home visit items for patients that are cared for by obstetricians throughout their pregnancy and birth. This new item represents a new service that is not currently funded through the MBS for obstetric patients. The new item requires that a mental health assessment must be performed as part of this service. This will benefit private patients who do not currently have access to state-funded home visits by a midwife.	The Committee is aware that there are many women who give birth as a private patient and do not currently receive a home visit by a midwife. This item will provide more support for women in the first few weeks after birth. This item will increase the number of women having a mental health assessment in the first few weeks after birth.

Recommendation 10: Obstetric services in rural and remote areas

The Committee recommends that the MBS Review Taskforce consider how to better support rural service delivery and in particular the role of financial incentives in supporting the provision of MBS funded health services in rural and remote Australia

Recommendation 11: Procedures on multiple pregnancies

Item	What it does	Committee recommendation	What would be different	Why
Remove items 16633 and 16636	For consumers who are pregnant with multiples (i.e. twins, triplets etc) and require certain tests or procedures – items 16600 to 16627 (for example amniocentesis) on more than one fetus, these items halve the amount of Medicare rebate patients receive for these tests and procedures for any additional fetus after the first.	To remove items 16633 and 16636.	Consumers who are pregnant with multiples (i.e.twins, triplets etc) will receive higher MBS rebates for tests and procedures that are performed on any additional fetus after the first. This will benefit patients as they will receive a higher MBS rebate for the second and subsequent fetus if they claim items 16600 to 16627.	The Committee note that items 16633 and 16636 were introduced because it was thought that it was quicker to do procedures on, say twins than it is to do procedures on two separate women. However the Committee recommend that it is more complex to do procedures on multiple pregnancies than when there is a single fetus and therefore the items should be removed.

Recommendation 12: Removal of ectopic pregnancy

Item	What it does	Committee recommendation	What would be different	Why
Remove 35676 and amend 35677	This item is used when an ectopic pregnancy is removed by a GP. Item 35677 is used when an ectopic pregnancy is removed by a specialist and has a higher fee than item 35676.	The Clinical Committee recommends that item 35676 is removed and that item 35677 is amended so that both GPs and specialists can access this item.	Patients will claim item 35677 instead which has a higher fee. This will benefit patients as they will receive a higher MBS rebate for the removal of an ectopic pregnancy when performed by a GP.	The Committee recommends that patients who require an ectopic pregnancy to be removed should receive the same MBS benefits if a GP or a specialist performs the service.

Recommendation 13: Obsolete items

Items 16504, 59503 and 59504 were removed from the MBS on 1 July 2016.

Recommendation 14: Simplify wording and updating terminology

Minor amendments to a number of items will have no impact on patients.

Recommendation 15: Consultation with an obstetrician when referred by a participating midwife

Item	What it does	Committee recommendation	What would be different	Why
16406	This item is used when a patient is cared for by a participating midwife (private patient) and the participating midwife wants advice from an obstetrician. This item can only be claimed when the patient is between 32 and 36 weeks gestation.	Allow this item to be claimed at any time during the patient's pregnancy.	Patients could claim this item which has a higher fee at any time during their pregnancy when the participating midwife requires advice from an obstetrician. This will benefit patients as it encourages collaboration between participating midwives and obstetricians and referral to an obstetrician earlier in their pregnancy.	The Committee is concerned that restricting this item to when the patient is between 32 and 36 weeks gestation discourages early collaboration between participating midwives and obstetricians. This change will allow higher benefits to be paid for a consultation with an obstetrician whenever this is required throughout a woman's pregnancy.

Recommendation 16: Antenatal pathology screening

The Committee agreed that to standardise antenatal pathology screening according to agreed national guidelines and improve health outcomes for pregnant women and their babies, there should be one item that includes all of the basic pathology tests that pregnant women should have done in the first trimester. This recommendation will be considered by the Pathology Clinical Committee and put out for public consultation later in 2016.

Appendix C Additional MBS data analysis – items 16590 & 16591

Item 16590 – Planning and management of a pregnancy where the doctor intends to undertake the delivery

Additional MBS data analysis

The Committee was concerned that some doctors are providing item 16590 and not providing the full suite of antenatal and delivery services required of the item.

Using a subset of patients who claimed a 20 week ultrasound in 2014, and then claimed item 16590 within one month after the 20 week ultrasound was performed (a total of 47,571 patients), we can determine if any other services were provided to these patients in their pregnancy by the same doctor that provided item 16590.

Statistics for this group of patients:

- 57 Obstetricians who provided item 16590 did not provide any other service to the patient in their pregnancy for 404 patients.
- 89 other medical practitioners (including GPs and other specialists) who provided item 16590 did not provide any other service to the patient in their pregnancy for 157 patients.

Source: Department of Health, unpublished data, date of service, processed until 29/2/2016.

Item 16591 – Planning and management of a pregnancy where the doctor does not intend to undertake the delivery (for example GP shared antenatal care)

Additional MBS data analysis

The Committee was concerned that some doctors providing item 16591 are not providing the full suite of antenatal services required of a shared care GP.

Using a subset of patients who claimed a 20 week ultrasound in 2014, and then claimed item 16591 within one month after the 20 week ultrasound was performed (a total of 16,944 patients), the other services were provided to these patients in their pregnancy by the same doctor that provided item 16591 can be determined.

In particular the number of services for item 16500 (antenatal attendance) or A1 items – 3, 23, 36, 44 etc (consultation items) that were provided by the same doctor that provided item 16591 were of interest. Ideally only item 16500 would have been used to exclude consultations for non-pregnancy related services throughout the pregnancy, however it is known that some GPs continue to claim item 23 etc for their antenatal attendances.

Statistics for this group of patients:

- Δ 249 GPs who provided item 16591 did not provide any antenatal or consultation service to the patient in their pregnancy for 643 patients (excluding non-core consultation items such as GP chronic disease health plans, GP mental health plan, health assessments etc).

Source: Department of Health, unpublished data, date of service, processed until 29/2/2016.

This data has been provided to the relevant policy area and compliance area for further analysis.

Addendum to the Obstetrics Clinical Committee report

A.1 MBS Reviews Taskforce review of public consultation submissions

The Obstetrics Clinical Committee report was released for public consultation on 9 September 2016 for four weeks.

The Obstetrics Clinical Committee considered public consultation feedback and agreed that three recommendations required minor changes. All other recommendations did not require amendment.

Recommendation 7

The Obstetrics Clinical Committee revised its recommendation, noting that it was appropriate to allow the new items for pregnancy complications that require an attendance of more than 40 minutes (currently funded through the MBS items 16508 and 16509) to be claimed up to three times per pregnancy, rather than just once.

Recommendation 8

The Obstetrics Clinical Committee revised its recommendation regarding a new item for a post-natal consultation by an obstetrician or GP which included a mental health assessment. Initially it was proposed that this item could be claimed between one and eight weeks after birth. However the Obstetrics Clinical Committee agreed the item should be amended so that it can only be claimed between four and eight weeks after birth.

This change was in response to advice from the Centre of Perinatal Excellence (COPE) who is funded by the Department to develop the Perinatal depression guidelines. COPE advised that mental health assessments should not be undertaken in the first four weeks after birth, as normal hormonal-related mood variations may lead to false positive mental health screens.

Recommendation 9

The Obstetrics Clinical Committee revised its recommendation regarding a new item for a home visit. Initially it was proposed that this item could be claimed between one and three weeks after birth and included a requirement that a mental health assessment must be undertaken. However the Obstetrics Clinical Committee agreed that this item should be able to be claimed between one and four weeks after birth, to line up with the revised item descriptor in Recommendation 8.

The requirement for a mental health assessment to be undertaken was removed in response to advice from the Centre of Perinatal Excellence (COPE) who is funded by the Department to develop the Perinatal depression guidelines. COPE advised that mental health assessments should not be undertaken in the first four weeks after birth, as normal hormonal-related mood variations may lead to false positive mental health screens.