Statutory Rules 1991 No. 351[1]

Health Insurance (1991-1992 General Medical Services Table) Regulations[2]

I, THE GOVERNOR-GENERAL of the Commonwealth of Australia, acting with the advice of the Federal Executive Council, make the following Regulations under the *Health Insurance Act 1973*.

Dated 20 November 1991.

BILL HAYDEN
Governor-General

By His Excellency's Command,

B. HOWE
Minister of State for Health, Housing and Community Services

Citation

1. These Regulations may be cited as the Health Insurance (1991-1992 General Medical Services Table) Regulations.

Commencement

2. These Regulations commence on 1 December 1991.

Repeal

3. Statutory Rules 1990 Nos. 342 and 436 and 1991 No. 83 are repealed.

General medical services table

4. The table of general medical services in the Schedule is prescribed for the purposes of subsection 4 (2) of the *Health Insurance Act 1973*.

SCHEDULE

Regulation 4

TABLE OF GENERAL MEDICAL SERVICES

RULES OF INTERPRETATION

1. (1) In this table, unless the contrary intention appears:

"attendance of a minor nature" or **"minor attendance"**, in relation to an attendance on a patient by a consultant physician, means an attendance that:

(a) is a second or subsequent attendance on the patient, in the course of a single course of treatment by the consultant physician, during which it is not necessary for the consultant physician to carry out a physical examination of the patient; and

(b) does not result in a substantial alteration to the treatment of the patient;

"institution" means a place (other than a hospital, a nursing home or accommodation for aged persons that is attached to a nursing home or situated within a nursing home complex) at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

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

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

(2) In this table, a reference by number to an item in the series 65001 to 73811 (inclusive) is a reference to the item so numbered in the pathology services table.

SCHEDULE—continued

(3) In this table, a reference by number to an item in the series 55000 to 61502 (inclusive) is a reference to the item so numbered in the diagnostic imaging services table.

(4) In this table, the symbol **"(AU** *n***)"** (where *n* is a number) is explained in items 17901 to 17959 (inclusive).

(5) In these Rules, **"referring practitioner"**, in relation to a referral, means:

(a) in the case of all referrals—a medical practitioner; and

(b) if the referral is given to a specialist who is an ophthalmologist—an optometrist; and

(c) if the referral:

(i) arises out of a dental service given by a dental practitioner; and

(ii) is given to a specialist (but not a consultant physician):

a dental practitioner.

2. (1) An item including the symbol **"(S)"** applies only to a service given by a specialist (and not to a service given by a consultant physician) in the practice of his or her specialty:

(a) to a patient who has been referred to the specialist, if the service is the first given by the specialist after the referral; or

(b) to a patient who has been referred to the specialist:

(i) if the service is part of a single course of treatment given for the condition identified in the referral; or

(ii) if no condition was identified in the referral—for the condition identified by the specialist; and

the service is given within the period of validity of the referral applicable under regulation 12 of the Health Insurance Regulations; or

(c) to a patient who has declared that a written referral completed by a named referring practitioner has been lost, stolen or destroyed before the service was given, if the service is the first given by the specialist in accordance with the referral; or

(d) to a patient who has not been referred to the specialist if, in an emergency, the specialist decides that it is necessary in the patient's interests to give the service as soon as practicable without a referral.

(2) An item including the symbol **"(G)"** applies only to a service given otherwise than by a specialist in accordance with subrule (1).

SCHEDULE—continued

3. (1) In subrule 1 (1), rules 2 and 4 and items 104, 105, 106, 107, 108, 110, 116, 119, 122, 128 and 131, **"single course of treatment"** includes:

(a) the:

(i) initial attendance by a specialist or consultant physician; and

(ii) continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and

(b) any subsequent review of the patient's condition by the specialist or consultant physician that may be necessary, whether the review is initiated by the referring practitioner or the specialist or consultant physician.

(2) For the purposes of subrule (1), an unrelated illness that requires referral of the patient to the specialist's or consultant physician's care, initiates a new course of treatment for which a new referral is required.

(3) For the purposes of subrule (1), if:

(a) a referring practitioner considers it necessary for a patient's condition to be reviewed; and

(b) the patient is attended by the specialist or consultant physician after the end of the period of validity of the last referral applicable under regulation 12 of the Health Insurance Regulations; and

(c) the patient was last attended by the specialist or consultant physician more than 9 months before the attendance mentioned in paragraph (b);

the attendance mentioned in paragraph (b) initiates a new course of treatment.

4. (1) In items 104 to 158 (inclusive), **"attendance"**, in relation to an attendance on a patient by a specialist, or consultant physician, in the practice or his or her specialty if the patient is referred to him or her:

(a) includes an attendance by a specialist, or consultant physician, in the practice of his or her specialty:

(i) if the patient has declared that a written referral of the patient was completed by a medical practitioner named in the declaration and that the referral has been lost, stolen or destroyed before the attendance; or

(ii) if, in an emergency, the patient has not been referred to the specialist, or consultant physician, who decides that it is necessary in the patient's interests to give the service mentioned in the item as soon as practicable without a referral; but

(b) does not include an attendance by a specialist, or consultant physician, in the practice of his or her specialty if:

SCHEDULE—continued

(i) the attendance forms part of a single course of treatment in which the first service was given more than 12 months (or such other period, if any, set by the referring practitioner in, or in connection with, the referral) before the attendance; and

(ii) a later referral has not been given.

(2) In items 104 to 158 (inclusive), a reference to the referring of a patient to a specialist, or consultant physician, is a reference to the referring of a patient to a specialist, or consultant physician, by a referring practitioner.

5. In items 3, 4, 13, 19, 20, 23, 24, 25, 33, 35, 36, 37, 38, 40, 43, 44, 47, 48, 50 and 51, **"professional attendance"** includes (but is not limited to) the provision in relation to a patient of 1 or more of the following services:

(a) the evaluation of the patient's condition or conditions including, if applicable, evaluation using the health screening services mentioned in in subsection 19 (5) of the Act;

(b) the formulation of a plan for the management and, if applicable, for the treatment of the patient's condition or conditions;

(c) the provision:

(i) of advice to the patient about the patient's condition or conditions and, if applicable, about treatment; and

(ii) if the patient has so authorised, of advice to another person, or other persons, about the patient's condition or conditions and, if applicable, about treatment;

(d) the recording of the clinical details of the service or services given to the patient.

6. (1) In items 13, 19 and 20, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 3; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $16.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—$1.15.

SCHEDULE—continued

(2) In items 25, 33 and 35, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 23; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $16.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—$1.15.

(3) In items 38, 40 and 43, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 36; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $16.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—$1.15.

(4) In items 48, 50 and 51, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 44; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $16.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—$1.15.

(5) In items 81, 87 and 92, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 52; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $10.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—70 cents.

SCHEDULE—continued

(6) In items 83, 89 and 93, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 53; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $10.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—70 cents.

(7) In items 84, 90 and 95, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 54; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $10.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—70 cents.

(8) In items 86, 91 and 96, **"amount under rule 6"** means an amount equal to the sum of:

(a) the fee set out in item 57; and:

(b) either:

(i) for each patient attended at a single attendance up to a maximum of 6 patients—an amount equal to $10.50 divided by the number of patients so attended; or

(ii) for each patient attended at a single attendance if the number of patients so attended is in excess of 6—70 cents.

7. Items 10815 and 10929 do not apply if the patient requires contact lenses only for one or more of the following reasons:

(a) because the patient does not want to wear spectacles for reasons of appearance; or

(b) because the patient wants contact lenses for work, or sporting, purposes; or

(c) because the patient has difficulty in using, or cannot use, spectacles for psychological reasons.

SCHEDULE—continued

8. For the purposes of item 10901, a patient has an ocular condition which clinically justifies a further course of attention within 24 months of the previous initial consultation only if the patient has:

(a) marked changes of visual acuity requiring general reassessment; or
(b) new symptoms, unrelated to the earlier course of attention, requiring general reassessment; or
(c) a binocular vision dysfunction requiring general reassessment to redefine treatment; or
(d) a progressive disorder, such as age related maculopathies, cataract, corneal dystrophies or keratoconus, requiring general reassessment; or
(e) ocular hypertension requiring general reassessment;or
(f) a diagnosed vascular disorder requiring comprehensive fundus inspection through dilated pupils.

9. (1) For the purposes of items 10921 to 10929 (inclusive), a patient has an ocular condition which necessitates a further course of attention within 36 months of the previous initial consultation only in the circumstances mentioned in subrules (2) and (3).

(2) The patient requires a change in contact lens material, or basic lens parameters, other than a simple power change, because of:

(a) a structural, or functional, change in the eye; or
(b) an allergic response.

(3) A lost, damaged or otherwise unsatisfactory contact lens is replaced by an optometrist:

(a) who:
    (i) does not have access to the original prescription; and
    (ii) does a total refit where an item mentioned in subrule (1) applies; and
(b) who is not:
    (i) the optometrist who initially fitted the contact lenses; or
    (ii) an optometrist at, or operating from, the same practice location at which the optometrist who initially fitted the contact lenses practised when the contact lenses were initially fitted.

10. (1) The items mentioned in subrule (2) apply only to a service given in the course of a personal attendance by a medical practitioner on a single patient on a single occasion.

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(2) The items are 3 to 153 (inclusive), 157 to 164 (inclusive), 173 to 10815 (inclusive), 11012, 11015, 11018, 11021, 11212, 11303, 11500, 11600, 11627, 11630, 11712, 11921, 12000, 12003, 12100, 12103, 12106, 12109 13000, 13003, 13006, 13009, 13100, 13103, 13106, 13109, 13112, 13209, 13300, 13303, 13306, 13309, 13312, 13315, 13318, 13400, 13500, 13503, 13600, 13603, 13606, 13700, 13703, 13706, 13709, 13800, 13803, 13806, 13900, 13903, 13906, 13909, 13912, 14200, 14203, 14206, 16000 to 16552 (inclusive) and 16558 to 51309 (inclusive).

(3) Items 154, 155, 156, 170, 171 and 172 apply only to a service given in the course of a personal attendance by a medical practitioner.

11. (1) The items mentioned in subrule (2) apply only to a service given in the course of a personal attendance by:

(a) a medical practitioner other than a medical practitioner employed by the proprietor of a hospital; or

(b) a medical practitioner:

(i) who is employed by the proprietor of a hospital; and

(ii) who gives the service otherwise than in the course of employment by that proprietor;

whether or not another person provides essential assistance to that medical practitioner in accordance with accepted medical practice.

(2) The items are 3 to 10815 (inclusive), 11012, 11015, 11018, 11021, 11212, 11303, 11500, 11600, 11627, 11630, 11712, 11921, 12000, 12003, 12100, 12103, 12106, 12109, 13000, 13003, 13006, 13009, 13100, 13103, 13106, 13109, 13112, 13209, 13300, 13303, 13306, 13309, 13312, 13315, 13318, 13400, 13500, 13503, 13600, 13603, 13606, 13700, 13703, 13706, 13709, 13800, 13803, 13806, 13900, 13903, 13906, 13909, 13912, 14200, 14203, 14206, 16000 to 16552 (inclusive) and 16558 to 51309 (inclusive).

12. The items mentioned in subrule (2) apply whether the medical service is given by:

(a) a medical practitioner; or

(b) a person, other than a medical practitioner, who is employed by a medical practitioner; or,

(c) a person who acts under the supervision of a medical practitioner in accordance with accepted medical practice.

SCHEDULE—continued

(2) The items are 11000, 11003, 11006, 11009, 11024, 11027, 11200, 11203, 11206, 11209, 11215, 11218, 11221, 11224, 11227, 11300, 11306, 11309, 11312, 11315, 11318, 11321, 11324, 11327, 11330, 11333, 11336, 11339, 11503, 11506, 11509, 11512, 11603, 11606, 11609, 11612, 11615, 11618, 11621, 11624, 11700, 11703, 11706, 11709, 11715, 11800, 11900, 11903, 11906, 11909, 11912, 11915, 11918, 12006, 12009, 12200, 12500 to 12530 (inclusive), 13200, 13203, 13206, 13212, 13215, 13218, 13221, 14050, 14053, 15000 to 15533 (inclusive) and 16555.

13. Items 11309, 11312, 11315, 11318 and 11321 apply only to a service given:

(a) in conditions that allow the establishment of determinate thresholds; and

(b) in a sound-attenuated environment with background noise conditions that comply with Australian Standard AS 1269-1983, of the Standards Association of Australia, as in force on 1 August 1987; and

(c) using calibrated equipment that complies with Australian Standard AS 2586-1983, of the Standards Association of Australia, as in force on 1 August 1987.

14. Items 51700 to 53439 (inclusive) apply only to a service given in the course of dental practice by a dental practitioner approved by the Minister for the purposes of the definition of "professional service" in subsection 3 (1) of the Act.

15. In items 18101 to 18122 (inclusive), **"administration of an anaesthetic"** means the administration of an anaesthetic in connection with a dental service, other than a dental service that is a prescribed medical service for the purposes of paragraph (b) of the definition of "professional service" in subsection 3 (1) of the Act.

16. In an item mentioned in subparagraph (b) (i), (ii), (iii), (iv), (v) or (vi), **"amount under rule 16"** means an amount equal to the sum of:

(a) the amount of the fee set out in the other item that applies to radiotherapy treatment of the kind mentioned in the first-mentioned item when given to 1 field only; and:

(b) the following amount:

(i) for item 15003—$11.80 for each field separately treated in excess of 1 up to a maximum of 5 additional fields; or

(ii) for item 15103—$13.00 for each field separately treated in excess of 1 up to a maximum of 5 additional fields; or

SCHEDULE—continued

(iii) for item 15109—$15.60 for each field separately treated in excess of 1 up to a maximum of 5 additional fields; or
(iv) for item 15204—$20.50 for each field separately treated in excess of 1 up to a maximum of 5 additional fields; or
(v) for item 15208—$20.50 for each field separately treated in excess of 1 up to a maximum of 5 additional fields; or
(vi) for item 15214—$17.20 for each field separately treated in excess of 1 up to a maximum of 5 additional fields.

17. In an item mentioned in subparagraph (b) (i) or (ii), **"amount under rule 17"** means an amount equal to the sum of:

(a) the amount of the fee set out in the other item that applies to treatment, by a single dose of radiotherapy, of the kind mentioned in the first-mentioned item when given to 1 field only; and:
(b) the following amount:
(i) for item 15009—$12.80 for each field separately treated in excess of 1 up to a maximum of 5 additional fields; or
(ii) for item 15115—$32.50 for each field separately treated in excess of 1 up to a maximum of 5 additional fields.

18. In an item to which paragraph (a) or (b) applies, **"amount under rule 18"** means an amount equal to:

(a) for item 17977—85% of the fee, for the administration of an anaesthetic, for the item relating to an original amputation of the kind performed (being any of items 44324 to 44373 (inclusive)); or
(b) for item 44376—75% of the fee for the item relating to an original amputation of the kind performed (being any of items 44324 to 44373 (inclusive)).

19. Items 75200 to 75854 (inclusive) that include the symbol **"(AD)"** apply only to a service given by a State registered dental practitioner practising as a dentist.

20. (1) In this rule:

"accredited orthodontist" means:

(a) a dental practitioner who is registered or licensed as an orthodontist or oral surgeon under the relevant law; or
(b) a dental practitioner:
(i) who is not registered or licensed under the relevant law as an orthodontist or an oral surgeon or who practises in a State or

SCHEDULE—continued

Territory in which there is no provision for the registration or licensing of orthodontists or oral surgeons; and

(ii) whose qualifications or experience demonstrate to the Committee his or her competence in the field of orthodontics that is applicable to the giving of the services specified in items 75000 to 75051 (inclusive); and

(iii) who is accredited by the Minister for the purposes of this rule;

"Committee" means the Medical Benefits (Dental Practitioners) Advisory Committee established under section 136 of the *National Health Act 1953*;

"relevant law", in relation to a service given to a patient, means the law of the State or Territory in which the service is given that provides for the registration or licensing of orthodontists or oral surgeons.

(2) Items 75000 to 75051 (inclusive) that include the symbol **"(AO)"** apply only to a service given by an accredited orthodontist.

21. (1) In this rule, **"relevant law"**, in relation to a service given to a patient, means the law of the State or Territory in which the service is given that provides for the registration or licensing of oral surgeons.

(2) Items 75200 to 75609 (inclusive) that include the symbol **"(AOS)"** apply only to a service given by a dental practitioner who is:

(a) registered under the relevant law as an oral surgeon; and

(b) a dental practitioner approved by the Minister for the purposes of the definition of "professional service" in subsection 3 (1) of the Act.

22. In items 11000 to 12200 (inclusive), **"report"** means a report prepared by a medical practitioner.

23. In rule 24 and items 13200 to 13221 (inclusive), **"treatment cycle of a patient"** means a series of treatments of the patient that:

(a) begins:

(i) if treatment with superovulatory drugs is given—on the day on which that treatment begins; or

(ii) if treatment with superovulatory drugs is not given—on the first day of the menstrual cycle of the patient; and

(b) ends not more than 30 days after that day.

SCHEDULE—continued

24. If a service mentioned:

(a) in an item in subgroup 3 of group T1 (invitro fertilisation); and

(b) in another item outside that subgroup;

is given as part of a treatment cycle to which that subgroup applies, it is not a medical service for the purposes of that other item.

25. Items 13200 to 13221 (inclusive) do not apply to a service in relation to a patient's pregnancy, or intended pregnancy, that is, at the time of the service, the subject of an agreement, or arrangement, under which the patient makes provision for guardianship of, or custodial rights to, a child born as a result of the pregnancy to be transferred to another person.

26. In items 13200 and 13206, **"embryology laboratory services"** includes:

(a) egg recovery from aspirated follicular fluid; and

(b) insemination; and

(c) monitoring of fertilisation and embryo development; and

(d) preparation of gametes or embryos for transfer or freezing;

but does not include semen preparation.

27. In items 16506, 16507, 16510, 16513, 16516 and 16517, **"confinement"** includes:

(a) induction of labour by surgical or intravenous infusion methods; and

(b) forceps or vacuum extraction; and

(c) breech delivery; and

(d) management of multiple deliveries; and

(e) episiotomy; and

(f) repair of tears; and

(g) a medical service mentioned in item 16558 or 16561 when performed at the time of delivery; and

(h) evacuation of the products of conception by manual removal.

28. The procedures mentioned within item 16516, 16517, 16520, 16564, 16567, 16570 or 16573 constitute, for the purposes of that item, a single operation for the purposes of subsections 16 (2), (3) and (4) of the Act.

29. In items 45719 to 45752 (inclusive) and 52342 to 52375 (inclusive), **"maxilla"** includes the zygoma.

SCHEDULE—continued

30. Items 46300 to 46510 apply only to a service given in the course of an operation on a hand or hands.

31. In items 47000 to 50239 (inclusive):

"closed reduction":

(a) means treatment of a dislocation or fracture by non-operative reduction; and

(b) includes the use of percutaneous fixation, or external splintage by cast or splints;

"open reduction" means treatment of a dislocation or fracture by either:

(a) operative exposure including the use of any internal or external fixation; or

(b) non-operative (closed reduction) where intra-medullary fixation or external fixation is used.

32. Items 48678, 48681, 48684, 48687 and 48690 apply only if the service is undertaken in association with a spinal fusion service to which item 48642, 48645, 48648, 48651, 48654, 48657, 48660, 48663, 48666, 48669, 48672 or 48675 applies.

33. In items 51303 and 51803, **"amount under rule 33"**, in relation to an amount payable for assistance at an operation, means an amount equal to one-fifth of the sum of the fees payable under the Act for the services at that operation of the practitioner to whom the assistance was given.

34. (1) In item 51309, **"amount under rule 34"** in relation to an amount payable for assistance at a series, or combination, of operations, means an amount equal to one-fifth of the sum of the fees payable under the Act for the services at those operations of the practitioner to whom the assistance was given.

(2) For the purposes of subrule (1), the amount payable for the Caesarean section component of the operations is the fee applicable to item 16520.