What is the Extended Medicare Safety Net?

Last Updated – November 2013

The Extended Medicare Safety Net (EMSN) provides an additional rebate for Australian families and singles who incur out-of-pocket costs for Medicare eligible out-of-hospital services. Once the relevant annual threshold of out-of-pocket costs has been met, Medicare will pay for 80% of any future out-of-pocket costs for out-of-hospital Medicare services for the remainder of the calendar year. However, there is an upper limit on the amount of benefit that can be paid under the EMSN for a small number of Medicare services.

There are two thresholds for the EMSN. These thresholds are indexed by the Consumer Price Index (CPI) on 1 January each year.

The 2013 annual EMSN thresholds are:

- **$610.70** for Commonwealth concession cardholders, including those with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card, and people who receive Family Tax Benefit (Part A); and
- **$1,221.90** for all other singles and families.

The 2014 annual EMSN thresholds, effective from 1 January 2014, will be:

- **$624.10** for Commonwealth concession cardholders, including those with a Pensioner Concession Card, a Health Care Card or a Commonwealth Seniors Card, and people who receive Family Tax Benefit (Part A); and
- **$1,248.70** for all other singles and families.

Couples and families should contact the Department of Human Services – Medicare to register their family members as part of a Medicare eligible family. Registering as a family allows eligible out-of-pocket costs for each individual family member to count toward the family's EMSN threshold. Couples and families need to register even if all family members are listed on the Medicare card. Registration is only required once unless family members change, for example, if a dependent child is no longer studying or you have a newborn baby.

What are out-of-hospital services?

Out-of-hospital services include GP and specialist attendances, services provided in private clinics and private emergency departments, and many pathology and diagnostic imaging services. However, many day surgery facilitates are classified as hospitals in Australia. The distinction between in-hospital and out-of-hospital services is not always obvious. It is important that patients talk with their doctors regarding the classification and likely out-of-pocket costs for their medical treatment, including any rebates paid through Medicare.

What services are not eligible for the EMSN?

In-hospital services are not eligible for the EMSN. Where people receive their treatment in-hospital as a private patient they are eligible for a Medicare rebate equal to 75 per cent of the Medicare Schedule fee. If they hold Private Health Insurance (PHI), they may also receive a rebate from their PHI fund.

The EMSN provides an additional Medicare rebate for eligible out-of-hospital services. It is not available for services for which a Medicare rebate is not paid and out-of-pocket costs for these services do not count towards the annual EMSN threshold.

What is EMSN benefit capping?

The EMSN benefit cap is the maximum amount of EMSN benefits payable for a Medicare Benefits Schedule (MBS) item regardless of the fee charged by the doctor. A full list of the affected MBS items and the levels of the EMSN benefit caps appears later in this document.

Why are some services capped?

Following an announcement in the 2009-2010 Budget, on 1 January 2010 some Medicare items were capped after they were identified as areas of concern in the Extended Medicare Safety Net Review Report 2009 (the Review report). The Review report showed that for some services, such as obstetrics and assisted reproductive technology (ART), the EMSN had been used by specialist doctors to raise their fees knowing the taxpayer would cover 80 per cent of the fee rise. This has implications for people that have not qualified for the EMSN. The EMSN benefit is intended to be a patient benefit; it is not intended to be a mechanism for doctors to increase their fees.

Since 1 January 2010 a number of MBS services have since been listed on the MBS with EMSN benefit caps in place. These services have been capped to maintain consistency with the existing capped items, or as a result of recommendations made by the Medical Services Advisory Committee (MSAC) regarding cost effectiveness.

The 2009 Extended Medicare Safety Net Review Report can be found on the Department of Health website.

EMSN benefit capping announced in the 2012-13 Budget

As announced in the 2012-13 Federal Budget, from 1 November 2012 EMSN benefit caps apply to all consultations (including allied health), 38 procedural items and one ultrasound item. The new caps are calculated based on a percentage of the MBS fee.

For consultation items the EMSN benefit cap is set at 300 per cent of the MBS fee, up to a maximum cap of $500. Therefore, if a consultation item has an MBS fee of $100, the EMSN benefit cap is $300. If the consultation item has an MBS fee of $200, the EMSN benefit cap is $500. Note: All consultations, including GP, specialist, consultant physician and allied health, will have an EMSN cap.

For the other 'non-consultation' items that were capped on 1 November 2012, the EMSN benefit cap is equal to 80 per cent of the MBS fee. For these items there is no upper limit on the setting of the cap. Therefore if an item has an MBS fee of $800, the EMSN benefit cap is $640.

The level of the EMSN benefit caps will increase in line with the MBS fees and rebates on November, rather than on 1 January of each year. This will ensure that a patient's maximum Medicare benefit (ie. the base Medicare rebate plus their EMSN benefit) will not change more than once in a calendar year.

The items capped in the 2012-13 Budget include those where excessive fees are being charged, where there has been excessive growth in EMSN benefits in the past few years, where the EMSN is being used to subsidise items that could be used for cosmetic purposes and where there is a risk that practitioners could shift excessive fees onto other items such as consultations.

How do the EMSN benefit caps work in practice?

Most people are not affected by capping. If you have a capped item you still receive the standard Medicare rebate for the service and once you have reached the EMSN threshold you are still eligible to receive EMSN benefits for all out-of-hospital services. EMSN benefit capping does not affect the way patients qualify for the EMSN, meaning that all out-of-pocket costs for all MBS services that have an EMSN benefit cap count toward the patients EMSN threshold.

All patients who have reached their EMSN threshold are eligible to receive an EMSN benefit up to the amount of the EMSN benefit cap each time that they claim for a capped service.

The EMSN benefit caps are recorded in Medicare Australia claiming systems and are applied by Medicare Australia at the time of processing the claim for payment. Practitioners are required to bill the Medicare item that best describes the service that they provide.

Additionally, under the *Health Insurance Act 1973*, the amount that is specified on the account must be the amount charged for the service that is specified. This means that any component for other goods or services that are not part of the MBS item that is being billed must not be included in the fee for that item. For example, the fee charged for a service cannot be loaded onto the fee for another service.

How do I calculate my EMSN benefit?

For a capped item the method for determining the EMSN benefit is the same, that is 80 per cent of the patient's out-of-pocket cost once the patient has reached the EMSN threshold. If this amount is greater than the EMSN benefit cap, the patient receives the EMSN benefit cap amount. If the calculated benefit is less than the EMSN benefit cap, the patient receives the calculated benefit (which is equal to 80 per cent of the out-of-pocket costs for the claim).

Out-of pocket cost is the difference between the fee charged by the doctor and the standard Medicare rebate received by the patient from Medicare before EMSN benefits are paid.

The following scenario illustrates how the EMSN caps work. The scenario assumes that the patient has already reached their EMSN threshold and is therefore eligible to receive EMSN benefits.

Item 16500, an antenatal attendance has an MBS Fee of $47.15, an out-of-hospital MBS rebate of $40.10 and an EMSN benefit cap of $32.95, for services provided after 1 January 2013.

Example 1:
If the doctor charges $70.00 for the service, the patient's out-of-pocket cost before EMSN benefits are paid is $29.90 (doctor's fee minus the MBS rebate received). The EMSN benefit for this service is calculated to be $23.95 (80% of the patient's out-of-pocket cost). As the calculated EMSN benefit is below the EMSN benefit cap amount of $32.95, the patient will receive the full $23.95 in EMSN benefits. As a result, the total cost incurred by the patient is $5.95.

Example 2:
If the doctor charges $90.00 for the service, the patient's out-of-pocket cost before EMSN benefits are paid is $49.90 (doctor's fee minus the MBS rebate received). The EMSN benefit for this service would be calculated to be $39.95 (80% of the out-of-pocket cost) however, as this item has an EMSN benefit cap, the patient will receive the cap amount of $32.95. As a result, the total cost incurred by the patient is $16.95.

The EMSN benefit caps only apply to out-of-hospital services, as EMSN benefits are only paid for out-of-hospital services. The EMSN benefit caps do not impact on the amount patients receive through their private health insurance.

The full list of MBS items is available online on the MBS website. The website lists all the Medicare services and the associated MBS schedule fees and rebates for each item. The EMSN benefit cap will appear in the item description on MBS online, if the item has an EMSN benefit cap.

Changes to Obstetrics and Assisted Reproductive Technology on 1 January 2010

With the introduction of EMSN capping on 1 January 2010, a number of structural changes were made to obstetrics and ART services, including the introduction of new items and changes to Medicare rebates and item descriptors. Some of these changes are outlines below:

Obstetrics

On 1 January 2010 two items for consultations relating to pregnancy, 16401 and 16404, were introduced into the obstetrics section of the MBS. These items have the same fee as specialist attendance items 104 and 105 however they carry an EMSN benefit cap. These items continue to be restricted to specialists.

The item for the planning and management of a pregnancy was split into two items. Item 16590 is claimable for planning and managing a pregnancy that has progressed beyond 20 weeks where the practitioner intends to perform the labour and delivery. Item 16591 is claimable for planning and managing a pregnancy that has progressed beyond 20 weeks where the practitioner does not intend to perform the labour and delivery.

With the introduction of capping the base Medicare rebates for 15 obstetrics items was increased at a cost of $157.6 million over four years. The Medicare rebates for obstetrics attendance items and labour and delivery items where increased by 10 per cent and 30 per cent respectively. In addition the Medicare rebate for item 16590 – planning and management of a pregnancy was increased significantly. This is of particular benefit to those women that do not qualify for EMSN benefits.

Assisted Reproductive Technology (ART)

With the introduction of capping, the Medicare items for ART services, including In-Vitro Fertilisation (IVF), were restructured in negotiation with the ART profession and patient group ACCESS. This structure better reflects current clinical practice. There are no restrictions on the number of ART cycles patients can have under Medicare.

Further information

For more information visit the Medicare website or contact the Department of Human Services - Medicare:

Medicare
GPO Box 9822
in your capital city

Phone: 132 011 (local call rate) 24 hours 7 days a week.
Email: medicare@medicareaustralia.gov.au

Further background on the EMSN is also available of the Department of Health website.

Capped Items

EMSN benefit caps apply to the MBS items outlined below. The EMSN benefit caps outlined below are for the calendar year 2013.

Item number	Description	Capping percentage	2013 EMSN benefit cap ($)
14201	Injection of poly-L-lactic acid for the treatment of severe facial lipoatrophy (initial session)	15%	35.55
14202	Injection of poly-L-lactic acid for the treatment of severe facial lipoatrophy (subsequent sessions)	15%	18.00
32500	Varicose vein treatment via injection of sclerosant	110%	120.80
32520	Varicose vein treatment of one leg using endovenous laser therapy	15%	80.05
32522	Varicose vein treatment of one leg using endovenous laser therapy	10%	79.35
42702	Cataract surgery	15%	114.10
45560	Hair Transplantation	35%	165.80

#Note: Actual EMSN benefit received depends on the out-of-pocket cost incurred by a patient.

Assisted Reproductive Technology

Item number	Description	2013 EMSN benefit cap ($)
13200	ART services - superovulated treatment cycle proceeding to oocyte retrieval – initial cycle in a calendar year	1,675.50
13201	ART services- superovulated treatment cycle proceeding to oocyte retrieval – subsequent cycle in a calendar year	2,432.15
13202	ART services – superovulated cycles that is cancelled prior to oocyte retrieval	64.95
13203	Ovulation monitoring services for artificial insemination	108.15
13206	ART services - natural treatment cycle or treatment cycle where oocyte growth & development is induced using oral medication only	64.95
13209	Planning and management of an ART treatment cycle	10.90
13210	Initiation of a professional attendance via videoconference, where that service relates to item 13209	5.30
13212	Oocyte retrieval	70.35

Item number	Description	2013 EMSN benefit cap ($)
13215	Transfer of embryos to the female reproductive system	48.70
13218	Preparation of frozen or donated embryos	702.65
13221	Preparation of semen for artificial insemination	21.70
13251	Intracytoplasmic sperm injection	108.15

#Note: Actual EMSN benefit received depends on the out-of-pocket cost incurred by a patient.

Obstetric services

Item number	Description	2013 EMSN benefit cap ($)
16399	Initiation of a professional attendance via videoconference, where that service relates to item 16401, 16404, 16406, 16500, 16590 or 16591	24.10
16400	Antenatal attendance by a nurse or midwife on the behalf of a medical practitioner	11.05
16401	Initial specialist attendance by a practitioner in the practice of obstetrics	54.90
16404	Subsequent specialist attendance by a practitioner in the practice of obstetrics	32.95
16406	32 to 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.	108.15
16500	Antenatal attendance	32.95
16501	External Cephalic Version for Breech Presentation, After 36 Weeks	65.90
16502	Attendance for treatment of Polyhydramnios, Unstable Lie, Multiple Pregnancy, Pregnancy Complicated by Diabetes or Anaemia, Threatened Premature Labour Treated by Bed Rest Only or Oral Medication	22.00
16504	Attendance for the treatment of Habitual Miscarriage by Injection of Hormones Each Injection Up to a Maximum of 12 Injections	22.00

Item number	Description	2013 EMSN benefit cap ($)
16505	Attendance for threatened Abortion, Threatened Miscarriage or Hyperemesis Gravidarum	22.00
16508	Attendance for Pregnancy Complicated by Acute Intercurrent Infection, Intrauterine Growth Retardation, Threatened Premature Labour With Ruptured Membranes or Threatened Premature Labour Treated by Intravenous Therapy	22.00
16509	Attendance for the treatment of Preeclampsia, Eclampsia or Antepartum Haemorrhage	22.00
16511	Purse String Ligation of Cervix	109.75
16512	Removal of Purse String Ligature of Cervix	32.95
16514	Antenatal Cardiotocography in the Management of High Risk Pregnancy	16.55
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	175.60
16518	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	175.60
16519	Management of Labour and Delivery by Any Means (Including Caesarean Section) Including Post-partum Care for 5 Days	329.15
16520	Management of Labour and Delivery by Any Means (Including Caesarean Section) Including Post-partum Care for 5 Days	329.15
16522	Management of complicated birth	438.90
16525	Management of Second Trimester Labour, With or Without Induction, for Intrauterine Fetal Death, Gross Fetal Abnormality or Life Threatening Maternal Disease	153.370
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.	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.	329.15
16564	Evacuation of Retained Products of Conception (Placenta, Membranes or Mole) As a Complication of Confinement, With or Without Curettage of the Uterus	219.45

Item number	Description	2013 EMSN benefit cap ($)
16567	Management of Postpartum Haemorrhage by Special Measures Such As Packing of Uterus	219.45
16570	Vaginal Correction of Acute Inversion of the Uterus	219.45
16571	Repair of Extensive Laceration or Lacerations of the Cervix	219.45
16573	Repair of Third Degree Tear, Involving Anal Sphincter Muscles and Rectal Mucosa	219.45
16590	Planning and Management of a Pregnancy That as Progressed Beyond 20 Weeks.	219.45
16591	Planning and Management of a Pregnancy where the care of the patient will be transferred to another medical practitioner for the labour and delivery	109.75
16600	Amniocentesis	32.95
16603	Chorionic villus sampling	65.90
16606	Fetal Blood Sampling From Umbilical Cord or Fetus	131.75
16609	Fetal Intravascular Blood Transfusion, Using Blood Already Collected, Including Neuromuscular Blockade, Amniocentesis and Fetal Blood Sampling.	252.40
16618	Amniocentesis, therapeutic	104.30
16624	Drainage of Fetal Fluid Filled Cavity	142.65
16627	Feto-amniotic Shunt, Insertion of, Into Fetal Fluid Filled Cavity, Including Neuromuscular Blockade and Amniocentesis	307.25
16633	Procedure On Multiple Pregnancies Relating to Items 16606, 16609, 16612, 16615 and 16627	230.50
16636	Procedure On Multiple Pregnancies Relating to Items 16600, 16603, 16618, 16621 and 16624	87.85

#Note: Actual EMSN benefit received depends on the out-of-pocket cost incurred by a patient.

Pregnancy ultrasounds

Item number	Description	2013 EMSN benefit cap ($)
55700	Pregnancy related scan - less than 12 weeks referred patient	32.95
55701^	Pregnancy related scan - less than 12 weeks referred patient	16.50
55703	Pregnancy related scan - less than 12 weeks non referred patient	16.55
55702^	Pregnancy related scan - less than 12 weeks non referred patient	8.30
55704	Pregnancy related scan - 12 to 16 weeks referred patient	38.50
55710^	Pregnancy related scan - 12 to 16 weeks referred patient	19.30
55705	Pregnancy related scan - 12 to 16 weeks non referred patient	16.55
55711^	Pregnancy related scan - 12 to 16 weeks non referred patient	8.30
55706	Pregnancy related scan - 17 to 22 weeks referred patient	54.90
55713^	Pregnancy related scan - 17 to 22 weeks referred patient	27.50
55707	Pregnancy related scan - rump length of 45 to 84mm referred patient	38.50
55714^	Pregnancy related scan - rump length of 45 to 84mm referred patient	19.30
55708	Pregnancy related scan - rump length of 45 to 84mm non referred patient	16.55
55716^	Pregnancy related scan - rump length of 45 to 84mm non referred patient	8.30

Item number	Description	2013 EMSN benefit cap ($)
55709	Pregnancy related scan - 17 to 22 weeks non referred patient	22.00
55717^	Pregnancy related scan - 17 to 22 weeks non referred patient	11.05
55712	Pregnancy related scan - 17 to 22 weeks referred patient by obstetrician	65.90
55719^	Pregnancy related scan - 17 to 22 weeks referred patient by obstetrician	32.95
55715	Pregnancy related scan - 17 to 22 weeks non referred patient, performed by obstetrician	22.00
55720^	Pregnancy related scan - 17 to 22 weeks non referred patient, performed by obstetrician	11.05
55718	Pregnancy related scan - after 22 weeks referred patient	54.90
55722^	Pregnancy related scan - after 22 weeks referred patient	27.50
55721	Pregnancy related scan - after 22 weeks referred patient by obstetrician	65.90
55724^	Pregnancy related scan - after 22 weeks referred patient by obstetrician	32.95
55723	Pregnancy related scan - after 22 weeks non referred patient	22.00
55726^	Pregnancy related scan - after 22 weeks non referred patient	11.05
55725	Pregnancy related scan - after 22 weeks non referred patient, performed by obstetrician	22.00
55727^	Pregnancy related scan - after 22 weeks non referred patient, performed by obstetrician	11.05
55729	Duplex scanning after 24th week	16.55

Item number	Description	2013 EMSN benefit cap ($)
55730^	Duplex scanning after 24th week	8.30
55762	Pregnancy related scan - 17 to 22 weeks non referred patient which identifies multiple pregnancy	32.95
55763^	Pregnancy related scan - 17 to 22 weeks non referred patient which identifies multiple pregnancy	16.50
55764	Pregnancy related scan - 17 to 22 weeks referred patient which identifies multiple pregnancy, performed by obstetrician	87.85
55765^	Pregnancy related scan - 17 to 22 weeks referred patient which identifies multiple pregnancy, performed by obstetrician	44.00
55766	Pregnancy related scan - 17 to 22 weeks non referred patient which identifies multiple pregnancy, performed by obstetrician	32.95
55767^	Pregnancy related scan - 17 to 22 weeks non referred patient which identifies multiple pregnancy, performed by obstetrician	16.50
55768	Pregnancy related scan - after 22 weeks referred patient which confirms multiple pregnancy	81.40
55769^	Pregnancy related scan - after 22 weeks referred patient which confirms multiple pregnancy	40.75
55770	Pregnancy related scan - after 22 weeks non referred patient which confirms multiple pregnancy	32.55
55771^	Pregnancy related scan - after 22 weeks non referred patient which confirms multiple pregnancy	16.30
55772	Pregnancy related scan - after 22 weeks referred patient by obstetrician which confirms multiple pregnancy	86.80
55773^	Pregnancy related scan - after 22 weeks referred patient by obstetrician which confirms multiple pregnancy	43.45
55774	Pregnancy related scan - after 22 weeks referred patient which confirms multiple pregnancy performed by obstetrician	38.00
55775^	Pregnancy related scan - after 22 weeks referred patient which confirms multiple pregnancy performed by obstetrician	19.05

#Note: Actual EMSN benefit received depends on the out-of-pocket cost incurred by a patient.
^ Items introduced under the Capital Sensitivity measure announced in the 2009-10 Federal Budget and claimable from 1 July 2011 for services provided using aged equipment.

Midwifery

Item number	Description	2013 EMSN benefit cap ($)
82100	Initial midwife attendance with a participating midwife - lasting at least 40 minutes	21.70
82105	Short antenatal attendance with a participating midwife - up to 40 minutes	16.30
82110	Long antenatal attendance with a participating midwife - lat least 40 minutes.	21.70
82115	Planning and management of pregnancy with a participating midwife that has progressed beyond 20 weeks lasting at least 90 minutes	54.10
82130	Short postnatal attendance with a participating midwife	16.30
82135	Long postnatal attendance with a participating midwife	21.70
82140	Six week postnatal attendance	16.30

#Note: Actual EMSN benefit received depends on the out-of-pocket cost incurred by a patient.

EMSN benefit caps on procedures announced in the 2012-13 Budget

Item Number	Description of service	Cap percentage	EMSN cap ($)
11700	Electrocardiography, tracing and report.	80%	25.00
14100	Laser photocoagulation for the treatment of vascular lesions	80%	122.00
20142	Initiation of management of anaesthesia for lens surgery	80%	95.05
30071	Diagnostic biopsy of skin or mucous membrane	80%	41.80
31200	Removal of tumour, cyst, ulcer or scar by surgical excision	80%	27.20
31205	Removal of tumour, cyst, ulcer or scar by surgical excision	80%	76.40
31521	Total male mastectomy	80%	346.80
31527	Subcutaneous male mastectomy	80%	416.20
31560	Excision of accessory breast tissue	80%	277.40
32501	Varicose vein treatment	80%	87.85
32504	Varicose vein treatment	80%	214.15
32507	Varicose vein treatment	80%	426.90
34106	Ligation of artery or vein	80%	233.40
35533	Vulvoplasty or labioplasty	80%	279.90
37619	Reversal of male sterilisation - vasovasostomy or vasoepididymostomy	80%	221.30
42590	Canthoplasty – eyelid surgery	80%	270.70
42738	Injection of a therapeutic substance into the eye	80%	240.60
42739	Injection of a therapeutic substance into the eye	80%	240.60
42740	Injection of a therapeutic substance into the eye	80%	240.60
45003	Single stage local myocutaneous flap repair to 1 defect, simple and small	80%	481.35
45025	Carbon dioxide laser for scaring on face or neck	80%	141.90
45026	Carbon dioxide laser for scaring on face or neck – more than 1 area	80%	318.85
45200	Single stage local flap, where indicated, to repair 1 defect, simple or small,	80%	227.50
45203	Single stage local flap, where indicated, to repair 1 defect, complicated or large,	80%	324.85
45206	Single stage local flap, where indicated, to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals	80%	306.85
45545	Reconstruction of nipple, areola or both	80%	498.05
45584	Liposuction	80%	505.40
45585	Liposuction	80%	505.40
45587	Meloplasty for correction of facial asymmetry due to soft tissue abnormality	80%	712.70
45614	Whole thickness reconstruction of eyelid other than by direct suture	80%	470.10
45617	Upper eyelid reduction	80%	188.05
45620	Lower eyelid reduction	80%	260.85
45623	Ptosis of eyelid (unilateral), correction of	80%	578.45
45624	Ptosis of eyelid, correction of, where previous ptosis surgery has been performed	80%	749.95
45632	Rhinoplasty, correction of lateral or alar cartilages	80%	409.60
45635	Rhinoplasty, correction of bony vault only	80%	470.10
45652	Rhinophyma, carbon dioxide laser or erbium laser excision-ablation of	80%	285.10
45659	Correction of lop ear, bat ear or similar deformity	80%	417.00
55054	Ulrasonic cross-sectional echography in conjunction with a surgical procedure using interventional techniques	80%	87.30

EMSN benefit caps on consultations and allied health items announced in the 2012-13 Budget (caps equal to 300% of the MBS fee up to a maximum of $500)

MBS group	Name of group	Item numbers
Group A1	GP attendances	3 – 51
Group A2	Other non-referred attendances	52 – 96
Group A3	Specialist attendances	99 – 109
Group A4	Consultant physician attendances	110 – 133
Group A5	Prolonged attendances	160 – 164
Group A6	Group therapy	170 – 172
Group A7	Acupuncture	173 – 199
Group A8	Consultant psychiatrist	288 – 370
Group A9	Contact lenses – attendances	10801 – 10816
Group A11	Urgent attendance after hours	597 – 600
Group A12	Consultant occupational physician	385 – 389
Group A13	Public health physician	410 – 417
Group A14	Health assessments	701 – 715
Group A15	GP management plans, team care arrangements, multidisciplinary care plans	721 – 880
Group A17	Domiciliary and residential management reviews	900 – 903
Group A18	GP attendance associated with a PIP incentive payment	2497 – 2559
Group A19	Other non-referred attendances associated with a PIP incentive payment	2598 – 2677
Group A20	GP mental health treatment	2700 – 2727
Group A21	Emergency physician	501 – 536
Group A22	GP after hours attendances	5000 – 5067
Group A23	Other non-referred after hours attendances	5200 – 5267
Group A24	Pain and palliative medicine	2801 – 3093
Group A26	Neurosurgery attendances	6007 – 6016
Group A27	Pregnancy support counselling	4001
Group A28	Geriatric medicine	141 – 149
Group A29	Early intervention services for children with autism, pervasive developmental disorder or disability	135 – 139
Group A30	Medical practitioner telehealth attendances	2100 – 2220
Group T6	Anaesthetic consultations	17609 – 17690
Group M3	Allied health services	10950 – 10970
Group M6	Psychological therapy services	80000 – 80020
Group M7	Focussed psychological strategies (allied mental health)	80100 – 80170
Group M8	Pregnancy support counselling	81000 – 81010
Group M9	Allied health group services	81100 – 81125
Group M10	Autism, pervasive developmental disorder and disability services	82000 – 82035
Group M11	Allied health services for Indigenous Australians who have had a health check	81300 – 81360
Group M12	Services provided by a practice nurse or registered Aboriginal health worker on behalf of a medical practitioner	10983 – 10989, 10997
Group M13	Midwife telehealth services	82150-82152
Group M14	Nurse practitioners	82200 - 82225