Medicare Benefits Schedule

Summary of Changes

Effective 1 July 2011

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Summary of Additions, Deletions, and Revisions undertaken since 1 January 2011

New Items are indicated as “New”, Amended item descriptions are indicated as “Amend” and amended fees are indicated as “Fee”.

New Items (New)

1 July 2011

99	112	137	139	149	288	389	2100	2122
2125	2126	2137	2138	2143	2147	2179	2195	2199
2220	2820	3015	6016	10983	10984	13210	14201	14202
16399	17609	18361	37217	55005	55007	55008	55010	55011
55013	55014	55016	55017	55019	55020	55022	55023	55025
55026	55059	55060	55061	55062	55063	55064	55119	55120
55121	55122	55123	55125	55131	55136	55220	55221	55222
55223	55224	55226	55227	55228	55229	55230	55232	55233
55235	55236	55601	55604	55701	55702	55710	55711	55713
55714	55716	55717	55719	55720	55722	55724	55726	55727
55730	55732	55734	55735	55737	55760	55763	55765	55767
55769	55771	55773	55775	55801	55803	55805	55807	55809
55811	55813	55815	55817	55819	55821	55823	55825	55827
55829	55831	55833	55835	55837	55839	55841	55843	55845
55847	55849	55851	55853	55855	56025	56026	57360	57361
57529	57530	57532	57533	57535	57536	57538	57539	57702
57705	57708	57711	57714	57717	57723	57911	57914	57917
57920	57923	57926	57929	57932	57935	57938	57941	57944
57947	57950	57953	57956	57959	57962	57965	57968	58102
58105	58111	58114	58117	58123	58124	58126	58127	58302
58308	58502	58505	58508	58511	58523	58526	58529	58702
58708	58717	58720	58723	58902	58905	58911	58914	58917
58920	58923	58926	58929	58935	58938	58941	59104	59301
59304	59307	59310	59313	59315	59319	59504	59701	59704
59713	59716	59719	59725	59734	59737	59740	59752	59755
59761	59764	60101	60501	60504	60507	60510	61110	61575
61620	61632	61651	61652	61653	61654	61655	61656	61657
61658	61659	61660	61661	61662	61663	61664	61665	61666
61667	61668	61669	61670	61671	61672	61673	61674	61675
61676	61677	61678	61679	61680	61681	61682	61683	61684
61685	61686	61687	61688	61689	61690	61691	61692	61693
61694	61695	61696	61697	61698	61699	61700	61701	61702
61703	61704	61705	61706	61707	61708	61709	61710	61711
61712	61713	61714	61715	61716	61717	61718	61719	61729
63013	63014	63016	63017	63074	63075	63076	63077	63078
63079	63080	63081	63082	63083	63084	63085	63104	63117
63119	63134	63135	63136	63157	63158	63186	63187	63188
63189	63190	63191	63192	63193	63194	63207	63208	63257
63258	63259	63260	63261	63262	63263	63264	63265	63282
63283	63284	63285	63310	63311	63313	63341	63342	63343
63345	63346	63347	63348	63364	63392	63393	63394	63407
63408	63419	63432	63433	63447	63448	63449	63455	63457
63458	63479	63481	63484	63486	66610	69380	73066	73067
73325	73326	73327	82030	82035	82150	82151	82152	82220
82221	82222	82223	82224	82225				

Deleted Items

1 July 2011

15360	15363	15541	38321	38324	38327	38330	61535	61544
61556	61562	61568	61574	61580	61589	61592	61613	61619
61625	61631	61634	61637	61643	61649			

Amended Description (Amend)

1 July 2011

135	289	12250	21981	37218	41767	41861	47915	47916
49833	49836	49837	49838	55600	55603	61538	61541	61553
61565	61571	61616	61622	61628	61640	61646	66605	66607
69333	71059	73051	73063	82000	82005	82010	82015	82020
82025								

Assist (Added)

No assist added to items.

Amended Fee (Fee)

1 July 2011

66659	66660	71057	71059	71200

SUMMARY OF CHANGES

REVIEW OF GENERAL MEDICAL SERVICES

- **Better Start for Children with Disability –** This initiative will deliver services on a similar basis to the Helping Children with Autism Program. A new group has been created, 'Group A29 – Early intervention services for children with autism, pervasive developmental disorder or disability' which contains three items, 135, 137 and 139: item 135 has been moved into Group A29 from Group A4; items 137 and 139 are new items for disability. A new Explanatory Note A14 has been included. 'Group M10 – Autism, pervasive developmental disorder and disability services' contains the amended items 82000-82025 and the new items 80230 and 80235 for allied health professional services for children with autism, pervasive developmental disorder or disability. Explanatory Note M.10.1 has been amended.
- **Telehealth** - 33 new items have been introduced on 1 July 2011 to allow Medicare Benefits to be paid for eligible Telehealth specialist consultations and clinical support services. These items have been introduced as part of the 2010-2011 budget initiative, "Connecting Health Services with the Future: Modernising Medicare by Providing Rebates for Online Consultations."
- **Facial Injections of Poly-L-lactic acid** - items 14201 and 14202 are being introduced following an MSAC recommendation that public funding be supported for the procedure for severe facial lipoatrophy caused by antiretroviral therapy.
- **Botulinum toxin** - New item for Injection of Botulinum toxin (Botox) for the treatment of moderate to severe spasticity in the upper limbs due to cerebral palsy, in a patient aged 2 to 17 years.
- **Intravascular Brachytherapy (IVBT) for Coronary Artery Restenoses** - IVBT items 15360, 15363, 15541, 38321, 38324, 38327, 38330 are being removed from the MBS following an MSAC recommendation that the procedure is no longer clinically relevant.
- **Anaesthetic amendment** - the operational restriction that the anaesthetic allergy testing be performed in association with anaesthetic has been removed
- **Gold fiducial seeds** - New interim item 37217 for the insertion of gold fiducial seeds into the prostate as markers for image guided radiotherapy (IGRT).
- **Amendments to Ear, Nose and Throat items –** item 41767 has been amended to expand the range of clinically relevant approaches that may be used for nasopharyngeal tumours. Item 41861 has been amended to allow for the removal of all benign lesions of the larynx.

REVIEW OF THE DIAGNOSTIC IMAGING SERVICES

From 1 July 2011 all services listed in the Diagnostic Imaging Services Table of the Medicare Benefits Schedule (MBS), excluding Positron Emission Tomography (PET) services, preparation items 60918 and 60927 and MRI modifier items in subgroup 22, will have a mirror NK item (50% of the Schedule Fee) for diagnostic imaging services provided on aged equipment. This rule, known as 'capital sensitivity', is currently in place for computed tomography (CT) and angiography and will be extended to improve the quality of diagnostic imaging services by encouraging providers to upgrade and replace aged equipment as appropriate.

REVIEW OF THE PATHOLOGY SERVICES

Seven new items, 66610, 69380, 73066, 73067, 73325, 73326 and 73327 have been introduced into the Pathology Services Table with a further six items, 66605, 66607, 69333, 71057, 71059 and 71200 amended to reflect a change either the descriptor or schedule fee.

SPECIALIST		SPECIALIST
	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
New 99	The initiation of a professional attendance via video conference by a specialist in the practice of his or her specialty, rendered to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 104 or 105. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.	
CONSULTANT PHYSICIAN		**CONSULTANT PHYSICIAN**
	GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
New 112	The initiation of a professional attendance via video conference by a consultant physician in the practice of his or her specialty, rendered to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 110, 116, 119, 132 or 133. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.	

GROUP A29 - EARLY INTERVENTION SERVICES FOR CHILDREN WITH AUTISM, PERVASIVE DEVELOPMENTAL DISORDER OR DISABILITY

Amend 135

CONSULTANT PAEDIATRICIAN, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER - SURGERY OR HOSPITAL

Professional attendance of at least 45 minutes duration at consulting rooms or hospital, by a consultant physician in his or her specialty of paediatrics, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant paediatrician by a medical practitioner, if the consultant paediatrician does the following:

(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)
(b) develops a treatment and management plan which must include the following:
  (i) the outcomes of the assessment;
  (ii) the diagnosis or diagnoses;
  (iii) opinion on risk assessment;
  (iv) treatment options and decisions;
  (v) appropriate medication recommendations, where necessary.
(c) provides a copy of the treatment and management plan to the:
  (i) referring practitioner; and
  (ii) relevant allied health providers (where appropriate).

Not being an attendance on a child in respect of whom payment has previously been made under this item or items 137, 139 or 289.

(See para A13 of explanatory notes to this Category)

Fee: $253.90 **Benefit:** 75% = $190.45 85% = $215.85

New 137

SPECIALIST OR CONSULTANT PHYSICIAN, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR A CHILD WITH AN ELIGIBLE DISABILITY - SURGERY OR HOSPITAL

Professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a specialist or consultant physician, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, who has been referred to the specialist or consultant physician by a medical practitioner, if the specialist or consultant physician does the following:

(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)
(b) develops a treatment and management plan which must include the following:
  (i) the outcomes of the assessment;
  (ii) the diagnosis or diagnoses;
  (iii) opinion on risk assessment;
  (iv) treatment options and decisions;
  (v) appropriate medication recommendations, where necessary.
(c) provides a copy of the treatment and management plan to the:
  (i) referring practitioner; and
  (ii) relevant allied health providers (where appropriate).

Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.

(See para A14 of explanatory notes to this Category)

Fee: $253.90 **Benefit:** 75% = $190.45 85% = $215.85

GENERAL PRACTITIONER CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR A CHILD WITH AN ELIGIBLE DISABILITY

Professional attendance of at least 45 minutes duration, at consulting rooms, by a general practitioner, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with an eligible disability, if the general practitioner does the following:

(a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate)
(b) develops a treatment and management plan which must include the following:
  (i) the outcomes of the assessment;
  (ii) the diagnosis or diagnoses;
  (iii) opinion on risk assessment;
  (iv) treatment options and decisions;
  (v) appropriate medication recommendations, where necessary.
(c) provides a copy of the treatment and management plan to the:
  (i) relevant allied health providers (where appropriate).

Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 139 or 289.

New 139

(See para A14 of explanatory notes to this Category)

Fee: $125.00 **Benefit:** 100% = $125.00

GROUP A28 - GERIATRIC MEDICINE

The initiation of a professional attendance via video conference rendered by a **consultant physician or specialist practising in the specialty of geriatric medicine** to a patient who is:

a) a care recipient receiving care in a residential aged care service; or
b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or
c) located outside an inner metropolitan area, not being an admitted patient;

being a service associated with item 141 or 143.

New 149

Derived Fee: 50% of the fee for the associated item. Benefit: 85% of derived fee.

CONSULTANT PSYCHIATRIST	CONSULTANT PSYCHIATRIST
	GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
New 288	The initiation of a professional attendance via video conference rendered by a **consultant physician practising in the specialty of psychiatry** to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 291, 293, 296, 300, 302, 304, 306, 308, 310, 312, 314, 316, 318, 319, 348, 350 or 352. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.
Amend 289	**CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND DEVELOPMENT OF A TREATMENT AND MANAGEMENT PLAN FOR AUTISM OR ANY OTHER PERVASIVE DEVELOPMENTAL DISORDER - SURGERY OR HOSPITAL** Professional attendance of at least 45 minutes duration, at consulting rooms or hospital, by a consultant physician in his or her specialty of psychiatry, for assessment, diagnosis and the preparation of a treatment and management plan for a child aged under 13 years, with autism or any other pervasive developmental disorder, who has been referred to the consultant psychiatrist by a medical practitioner, if the consultant psychiatrist does the following: (a) undertakes a comprehensive assessment of the child and forms a diagnosis (using the assistance of one or more allied health providers where appropriate) (b) develops a treatment and management plan which must include the following: (i) the outcomes of the assessment; (ii) the diagnosis or diagnoses; (iii) opinion on risk assessment; (iv) treatment options and decisions; (v) appropriate medication recommendations, where necessary. (c) provides a copy of the treatment and management plan to the: (i) referring practitioner; and (ii) relevant allied health providers (where appropriate). Not being an attendance on a child in respect of whom payment has previously been made under this item or items 135, 137 or 139. *(See para A13 of explanatory notes to this Category)* **Fee:** $253.90 **Benefit:** 75% = $190.45 85% = $215.85
CONSULT OCCUPATIONAL PHYSICIAN	**CONSULT OCCUPATIONAL PHYSICIAN**
	GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
New 389	The initiation of a professional attendance via video conference rendered by a **consultant occupational physician practising in the specialty of occupational medicine**, to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 385 or 386. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.

	GROUP A30 - MEDICAL PRACTITIONER (INCLUDING A GENERAL PRACTITIONER, SPECIALIST OR CONSULTANT PHYSICIAN) TELEHEALTH ATTENDANCES
	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
New 2100	**Level A – Telehealth attendance at consulting rooms** A professional attendance at consulting rooms (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, who is not an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $21.60 **Benefit:** 100% = $21.60
New 2122	**Level A – Telehealth attendance other than at consulting rooms** A professional attendance other than at consulting rooms (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is located outside an inner metropolitan area, not being an admitted patient, and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2100 plus $24.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $1.85 per patient.
	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
New 2125	**Level A - Telehealth attendance at a residential aged care facility** A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 5 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit) and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2100 plus $44.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2100 plus $3.15 per patient.
	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
New 2126	**Level B - Telehealth attendance at consulting rooms** A professional attendance at consulting rooms (not being a service to which any other item applies) lasting less than 20 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, who is not an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $47.10 **Benefit:** 100% = $47.10
New 2137	**Level B – Telehealth attendance other than at consulting rooms** A professional attendance other than at consulting rooms (not being a service to which any other item applies) lasting less than 20 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is located outside an inner metropolitan area, not being an admitted patient, and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2126 plus $24.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $1.85 per patient.

	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
New 2138	**Level B - Telehealth attendance at residentail aged care facility** A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting less than 20 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2126 plus $44.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2126 plus $3.15 per patient.
	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
New 2143	**Level C - Telehealth attendance at consulting rooms** A professional attendance at consulting rooms (not being a service to which any other item applies) lasting at least 20 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, who is not an admitted patient; b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $91.35 **Benefit:** 100% = $91.35
New 2147	**Level C –Telehealth attendance other than at consulting rooms** A professional attendance other than at consulting rooms (not being a service to which any other items applies) lasting at least 20 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is located outside an inner metropolitan area, not being an admitted patient, and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2143 plus $24.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $1.85 per patient.
	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
New 2179	**Level C - Telehealth attendance at residentail aged care facility** A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 20 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2143 plus $44.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2143 plus $3.15 per patient.
	SUBGROUP 1 - TELEHEALTH ATTENDANCE AT CONSULTING ROOMS, HOME VISITS OR OTHER INSTITUTIONS
New 2195	**Level D - Telehealth attendance at consulting rooms** A professional attendance at consulting rooms (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, who is not an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $134.40 **Benefit:** 100% = $134.40
New 2199	**Level D – Telehealth attendance other than at consulting rooms** A professional attendance other than at consulting rooms (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) by a medical practitioner that requires the provision of clinical support to a patient who is located outside an inner metropolitan area, not being an admitted patient, and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2195 plus $24.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $1.85 per patient.

ATTENDANCES	TELEHEALTH ATTENDANCE
	SUBGROUP 2 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
New 2220	**Level D - Telehealth attendance at residentail aged care facility** A professional attendance by a medical practitioner (not being a service to which any other item applies) lasting at least 40 minutes (whether or not continuous) that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex where the patient is a resident of the aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician, on 1 occasion - each patient. **Derived Fee:** The fee for item 2195 plus $44.05 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2195 plus $3.15 per patient.
PAIN AND PALLIATIVE MEDICINE	**PAIN MEDICINE**
	GROUP A24 - PAIN AND PALLIATIVE MEDICINE
	SUBGROUP 1 - PAIN MEDICINE ATTENDANCES
New 2820	The initiation of a professional attendance via video conference rendered by a **consultant physician or specialist practising in the specialty of pain medicine** to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 2801, 2806 or 2814. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.
	SUBGROUP 3 - PALLIATIVE MEDICINE ATTENDANCES
New 3015	The initiation of a professional attendance via video conference rendered by a **consultant physician or specialist practising in the specialty of palliative medicine** to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 3005, 3010 or 3014. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.
ATTENDANCES	**ATTENDANCES**
	GROUP A26 - NEUROSURGERY ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
New 6016	The initiation of a professional attendance via video conference rendered by a **specialist practising in the specialty of neurosurgery** to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or b) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 6007, 6009, 6011, 6013 or 6015. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee.

DIAGNOSTIC	OTHER
	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
Amend 12250	Overnight investigation for sleep apnoea for a period of at least 8 hours duration for a patient aged 18 years or more, if all of the following requirements are met: (a) the patient has, before the overnight investigation, been referred to a qualified adult sleep medicine practitioner by a medical practitioner whose clinical opinion is that there is a high probability that the patient has obstructive sleep apnoea; and (b) the investigation takes place after the qualified adult sleep medicine practitioner has: (i) confirmed the necessity for the investigation; and (ii) communicated this confirmation to the referring medical practitioner; and (c) during a period of sleep, the investigation involves recording a minimum of seven physiological parameters which must include: (i) continuous electro-encephalogram (EEG); and (ii) continuous electro-cardiogram (ECG; and (iii) airflow; and (iv) thoraco-abdominal movement; and (v) oxygen saturation; and (vi) 2 or more of the following: (A) electro-oculogram (EOG); (B) chin electro-myogram (EMG); (C) body position; and (d) in the report on of the investigation, the qualified adult sleep medicine practitioner uses the data specified in paragraph (c) to: (i) analyse sleep stage, arousals and respiratory events; and (ii) assess clinically significant alteration in heart rate; and (e) the qualified adult sleep medicine practitioner: (i) before the investigation takes place, establishes quality assurance procedures for data acquisition; and (ii) personally analyses the data and writes the report on the results of the investigation. Payable only once in a 12 month period. *(See para D1.26 of explanatory notes to this Category)* **Fee:** $322.60 **Benefit:** 75% = $241.95 85% = $274.25

MISCELLANEOUS	ASSISTED REPRODUCTIVE SERVICES
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES
New 13210	The initiation of a professional attendance via video conference rendered by a **specialist** practising in his or her specialty to a patient who is: a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient; being a service associated with item 13209. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee **Extended Medicare Safety Net Cap:** $5.00
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES
New 14201	POLY-L-LACTIC ACID, one or more injections of, for the initial session only, for the treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 - once per patient *(See para T1.16 of explanatory notes to this Category)* **Fee:** $227.90 **Benefit:** 75% = $170.95 85% = $193.75 **Extended Medicare Safety Net Cap:** $34.15
New 14202	POLY-L-LACTIC ACID, one or more injections of (subsequent sessions), for the continuation of treatment of severe facial lipoatrophy caused by antiretroviral therapy, when prescribed in accordance with the National Health Act 1953 *(See para T1.16 of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05 **Extended Medicare Safety Net Cap:** $17.30
OBSTETRICS	**OBSTETRICS**
	GROUP T4 - OBSTETRICS
New 16399	The initiation of a professional attendance via video conference rendered by a **specialist practising in the specialty of obstetrics** to a patient who is a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient being a service associated with item 16401, 16404, 16406, 16500, 16590 or 16591. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee **Extended Medicare Safety Net Cap:** $22.95
ANAESTHETICS	**CONSULTATIONS**
	GROUP T6 - ANAESTHETICS
	SUBGROUP 1 - ANAESTHESIA CONSULTATIONS
New 17609	The initiation of a professional attendance via video conference rendered by a **specialist practising in the specialty of anaesthesia** to a patient who is a) a care recipient receiving care in a residential aged care service; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or c) located outside an inner metropolitan area, not being an admitted patient being a service associated with item 17610, 17615, 17620, 17625, 17640, 17645, 17650, 17655 or 17690. **Derived Fee:** 50% of the fee for the associated item. Benefit: 85% of derived fee

BOTULINUM TOXIN INJECTIONS	**BOTULINUM TOXIN INJECTIONS**
	GROUP T11 - BOTULINUM TOXIN INJECTIONS
New 18361	Botulinum toxin (Botox), injection of, for the treatment of moderate to severe upper limb spasticity due to cerebral palsy, in a patient who is at least 2 years but less than 18 years, in association with either: (a) physiotherapy or occupational therapy or both; or (b) electrical stimulation or ultrasound for muscle localisation; including all injections for any or all of the muscles sub-serving one functional activity supplied by one motor nerve — with a maximum of four treatments per patient on any one day, and with a maximum of two treatments per limb (Anaes.) *(See para T11.1 of explanatory notes to this Category)* **Fee:** $120.10 **Benefit:** 75% = $90.10 85% = $102.10
RELATIVE VALUE GUIDE	**ANAESTHESIA**
	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE
	SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES
Amend 21981	**ANAESTHETIC AGENT ALLERGY TESTING**, using skin sensitivity methods in a patient with a history of prior anaphylactic or anaphylactoid reaction or cardiovascular collapse associated with the management of anaesthesia agents (4 basic units) **Fee:** $76.20 **Benefit:** 75% = $57.15 85% = $64.80
OPERATIONS	**UROLOGICAL**
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 5 - UROLOGICAL
	OPERATIONS ON PROSTATE
New 37217	Prostate, implantation of gold fiducial markers into the prostate gland or prostate surgical bed (Anaes.) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $133.05 **Benefit:** 75% = $99.80 85% = $113.10
Amend 37218	PROSTATE, needle biopsy of, or injection into, excluding for insertion of radiopaque markers (Anaes.) **Fee:** $133.05 **Benefit:** 75% = $99.80 85% = $113.10
	SUBGROUP 8 - EAR, NOSE AND THROAT
Amend 41767	NASOPHARYNGEAL ANGIOFIBROMA, removal of (Anaes.) (Assist.) **Fee:** $709.05 **Benefit:** 75% = $531.80 85% = $637.85
Amend 41861	MICROLARYNGOSCOPY with removal of benign lesions of the larynx by laser surgery (Anaes.) (Assist.) **Fee:** $581.40 **Benefit:** 75% = $436.05
	SUBGROUP 15 - ORTHOPAEDIC
	GENERAL
Amend 47915	INGROWING NAIL OF TOE, wedge resection for, with removal of segment of nail, ungual fold and portion of the nail bed (Anaes.) **Fee:** $163.10 **Benefit:** 75% = $122.35 85% = $138.65
Amend 47916	INGROWING NAIL OF TOE, partial resection of nail, with destruction of nail matrix by phenolisation, electrocautery, laser, sodium hydroxide or acid but not including excision of nail bed (Anaes.) **Fee:** $81.90 **Benefit:** 75% = $61.45 85% = $69.65

	SUBGROUP 15 - ORTHOPAEDIC
	GENERAL
	FOOT
Amend 49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $498.20 **Benefit:** 75% = $373.65
Amend 49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $860.50 **Benefit:** 75% = $645.40
Amend 49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - unilateral (Anaes.) (Assist.) **Fee:** $622.75 **Benefit:** 75% = $467.10
Amend 49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallicus tendon, with or without internal fixation and with or without excision of exostoses associated with the first metatarsophalangeal joint - bilateral (Anaes.) (Assist.) **Fee:** $1,075.40 **Benefit:** 75% = $806.55

	GROUP I1 - ULTRASOUND
	SUBGROUP 1 - GENERAL
New 55005	HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55007	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service 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)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55008	ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55010	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service 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)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55011	NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55013	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service 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)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55014	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in Subgroup 4,applies, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55017, 55020, 55038, 55044, 55731 or 55732 on the same patient within 24 hours (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.65 **Benefit:** 75% = $41.75 85% = $47.35
New 55016	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service to which an item in Subgroup 4,applies where the patient is not referred by a medical practitioner, not being a service 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)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15

ULTRASOUND		GENERAL
New 55017	URINARY TRACT, ultrasound scan of but not being a service associated with the service to which an item in Subgroup 4,applies,,where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55041, 55020, 55036, 55044, 55731 or 55732 on the same patient within 24 hours (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40	
New 55019	URINARY TRACT, ultrasound scan of, but not being a service associated with the service to which an item in Subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service 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)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15	
New 55020	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service to which an item in Subgroup 4,applies, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.65 **Benefit:** 75% = $41.75 85% = $47.35	
New 55022	PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service to which an item in Subgroup 4,applies, where the patient is not referred by a medical practitioner, not being a service 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)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15	
New 55023	SCROTUM, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.75 **Benefit:** 75% = $41.10 85% = $46.55	
New 55025	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (NK) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15	
New 55026	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40	
New 55059	BREAST, one, ultrasound scan of, 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 practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80	
New 55060	BREAST, one, ultrasound scan of, 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 (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.05 **Benefit:** 75% = $12.80 85% = $14.50	

New 55061	BREASTS, both, ultrasound scan of, 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 practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55062	BREASTS, both, ultrasound scan of, 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 (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55063	URINARY BLADDER, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of the Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55600, 55601, 55603, 55604, 55014, 55017, 55020, 55036, 55038, 55044, 55731, 55732 or 11917 on the same date of service (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80
New 55064	URINARY BLADDER, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 applies; and the service is not performed with item 55600, 55601, 55603, 55604, 55016, 55019, 55022, 55037, 55039, 55045, 55733, 55734 or 11917 on the same date of service (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.05 **Benefit:** 75% = $12.80 85% = $14.50
	SUBGROUP 2 - CARDIAC
New 55119	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
New 55120	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
New 55121	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup (with the exception of items 55118, 55125, 55130 and 55131), applies, for the investigation of symptoms or signs of congenital heart disease (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $115.35 **Benefit:** 75% = $86.55 85% = $98.05
New 55122	EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118, 55125, 55130 and 55131). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25

ULTRASOUND		VASCULAR
New 55123	PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118, 55125, 55130 and 55131). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $130.85 **Benefit:** 75% = $98.15 85% = $111.25	
New 55125	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 3, applies (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $137.75 **Benefit:** 75% = $103.35 85% = $117.10	
New 55131	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with items 55135 and 55136 (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25	
New 55136	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with items 55130 and 55131 (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $176.80 **Benefit:** 75% = $132.60 85% = $150.30	
	SUBGROUP 3 - VASCULAR	
New 55220	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55221	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for acute venous thrombosis, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55222	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the lower limb, below the inguinal ligament, for chronic venous disease, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55223	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the upper limb OR of arteries and bypass grafts in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55224	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of veins in the upper limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	

ULTRASOUND		VASCULAR
New 55226	DUPLEX SCANNING, bilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of extra-cranial bilateral carotid and vertebral vessels, with or without subclavian and innominate vessels, with or without oculoplethysmography or peri-orbital Doppler examination, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Groups applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55227	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-abdominal, aorta and iliac arteries or inferior vena cava and iliac veins OR of intra-abdominal, aorta and iliac arteries and inferior vena cava and iliac veins, excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55228	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of renal or visceral vessels OR of renal and visceral vessels, including aorta, inferior vena cava and iliac vessels as required excluding pregnancy related studies, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55229	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of intra-cranial vessels, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55230	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal artery of the penis following intracavernosal administration of a vasoactive agent, performed during the period of pharmacological activity of the injected agent, to confirm a diagnosis of vascular aetiology for impotence, where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55232	DUPLEX SCANNING involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of cavernosal tissue of the penis to confirm a diagnosis and, where indicated, assess the progress and management of: (a) priapism; or (b) fibrosis of any type; or (c) fracture of the tunica; or (d) arteriovenous malformations; where a specialist in diagnostic radiology, nuclear medicine, urology, general surgery (sub-specialising in vascular surgery) or a consultant physician in nuclear medicine attends the patient in person at the practice location where the service is rendered, immediately prior to or for a period during the rendering of the service, and that specialist or consultant physician interprets the results and prepares a report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Groups applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55233	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of surgically created arteriovenous fistula or surgically created arteriovenous access graft in the upper or lower limb, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054) or 4 of this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	
New 55235	DUPLEX SCANNING, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or veins OR arteries and veins, for mapping of bypass conduit prior to vascular surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $84.75 **Benefit:** 75% = $63.60 85% = $72.05	

New 55236	DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow spectral analysis and marking of veins in the lower limb below the inguinal ligament prior to varicose vein surgery, not being a service associated with a service to which an item in Subgroups 1 (with the exception of items 55026 and 55054), 3 or 4 of this Group applies - including any associated skin marking (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.55 **Benefit:** 75% = $41.70 85% = $47.25
	SUBGROUP 4 - UROLOGICAL
Amend 55600	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
New 55601	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner (not being the medical practitioner who assessed the patient as specified in (c)) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
Amend 55603	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i)examined the patient in the 60 days prior to the scan; and (ii)recommended the scan for the management of the patient's current prostatic disease (R) (K) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.10 **Benefit:** 75% = $81.85 85% = $92.75
New 55604	PROSTATE, bladder base and urethra, ultrasound scan of, where performed: (a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes that: (i) have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz; and (ii) can obtain both axial and sagittal scans in 2 planes at right angles; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL

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)

New 55701

Fee: $30.00 **Benefit:** 75% = $22.50 85% = $25.50

Extended Medicare Safety Net Cap: $15.70

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

(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)

New 55702

Fee: $17.50 **Benefit:** 75% = $13.15 85% = $14.90

Extended Medicare Safety Net Cap: $7.90

ULTRASOUND	OBSTETRIC AND GYNAECOLOGICAL
	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; (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)*
New 55710	**Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $18.35

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;
- (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)

New 55711

Fee: $17.50 **Benefit:** 75% = $13.15 85% = $14.90

Extended Medicare Safety Net Cap: $7.90

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)

New 55713

Fee: $50.00 **Benefit:** 75% = $37.50 85% = $42.50

Extended Medicare Safety Net Cap: $26.20

New 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)* **Fee:** $35.00 **Benefit:** 75% = $26.25 85% = $29.75 **Extended Medicare Safety Net Cap:** $18.35
New 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)* **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90 **Extended Medicare Safety Net Cap:** $7.90
New 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 (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)* **Fee:** $19.00 **Benefit:** 75% = $14.25 85% = $16.15 **Extended Medicare Safety Net Cap:** $10.50
New 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)* **Fee:** $57.50 **Benefit:** 75% = $43.15 85% = $48.90 **Extended Medicare Safety Net Cap:** $31.40
New 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)* **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00 **Extended Medicare Safety Net Cap:** $10.50

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;
- (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)

New 55722

Fee: $50.00 **Benefit:** 75% = $37.50 85% = $42.50

Extended Medicare Safety Net Cap: $26.20

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 Obstericians 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)

New 55724

Fee: $57.50 **Benefit:** 75% = $43.15 85% = $48.90

Extended Medicare Safety Net Cap: $31.40

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);
- (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)

New 55726 **Fee:** $19.00 **Benefit:** 75% = $14.25 85% = $16.15
Extended Medicare Safety Net Cap: $10.50

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 Obstetricans 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)

New 55727 **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00
Extended Medicare Safety Net Cap: $10.50

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)

New 55730 **Fee:** $13.65 **Benefit:** 75% = $10.25 85% = $11.65
Extended Medicare Safety Net Cap: $7.90

New 55732	PELVIS, FEMALE, ultrasound scan of, 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 practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (d) the service is not performed with item 55014, 55017, 55036 or 55038 on the same patient within 24 hours (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.00 **Benefit:** 75% = $36.75 85% = $41.65
New 55734	PELVIS, FEMALE, ultrasound scan of, 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 (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90
New 55735	PELVIS, FEMALE, 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)* **Fee:** $63.50 **Benefit:** 75% = $47.65 85% = $54.00
New 55737	PELVIS, FEMALE, 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)* **Fee:** $28.50 **Benefit:** 75% = $21.40 85% = $24.25
New 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)* **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75
New 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 (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)* **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $15.70

New 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 Obstericians 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)* **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00 **Extended Medicare Safety Net Cap:** $41.90
New 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)* **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Extended Medicare Safety Net Cap:** $15.70
New 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 (b) the ultrasound confirms a multiple pregnancy; and (c) the patient is referred by a medical practitioner or participating nurse 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)* **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75 **Extended Medicare Safety Net Cap:** $39.30
New 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)* **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50 **Extended Medicare Safety Net Cap:** $15.70

New 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 Obstericians 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)* **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00 **Extended Medicare Safety Net Cap:** $41.90
New 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: (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)* **Fee:** $32.50 **Benefit:** 75% = $24.40 85% = $27.65 **Extended Medicare Safety Net Cap:** $18.35
	SUBGROUP 6 - MUSCULOSKELETAL
New 55801	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55803	HAND OR WRIST, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55805	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55807	FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15

New 55809	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55811	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone. SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, suspraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55813	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55815	CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55817	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55819	HIP OR GROIN, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies: and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55821	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

New 55823	PAEDIATRIC HIP EXAMINATION FOR DYSPLASIA, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55825	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55827	BUTTOCK OR THIGH, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55829	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55831	Note: Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including: - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55833	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55835	LOWER LEG, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15

New 55837	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the services is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55839	ANKLE OR HIND FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55841	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55843	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55845	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.70 **Benefit:** 75% = $32.80 85% = $37.15
New 55847	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15
New 55849	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 or 55026 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40
New 55851	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55026, 55054, or 55800 to 55849, and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $76.45 **Benefit:** 75% = $57.35 85% = $65.00
New 55853	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $54.55 **Benefit:** 75% = $40.95 85% = $46.40

ULTRASOUND	MUSCULOSKELETAL
New 55855	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $18.95 **Benefit:** 75% = $14.25 85% = $16.15

	GROUP I2 - COMPUTED TOMOGRAPHY
New 56025	CONE BEAM COMPUTED TOMOGRAPHY of teeth and supporting bone structures (R) (K) (Anaes.) *(See para DID and DIQ of explanatory notes to this Category)* **Fee:** $113.15 **Benefit:** 75% = $84.90 85% = $96.20
New 56026	CONE BEAM COMPUTED TOMOGRAPHY of teeth and supporting bone structures (R) (NK) (Anaes.) *(See para DID and DIQ of explanatory notes to this Category)* **Fee:** $56.60 **Benefit:** 75% = $42.45 85% = $48.15
New 57360	COMPUTED TOMOGRAPHY OF THE CORONARY ARTERIES performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: a) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; or b) the patient requires exclusion of coronary artery anomaly or fistula; or c) the patient will be undergoing non-coronary cardiac surgery (R) (K) (Anaes.) *(See para DIL and DIQ of explanatory notes to this Category)* **Fee:** $700.00 **Benefit:** 75% = $525.00 85% = $628.80
New 57361	COMPUTED TOMOGRAPHY OF THE CORONARY ARTERIES performed on a minimum of a 64 slice (or equivalent) scanner, where the request is made by a specialist or consultant physician, and: a) the patient has stable symptoms consistent with coronary ischaemia, is at low to intermediate risk of coronary artery disease and would have been considered for coronary angiography; or b) the patient requires exclusion of coronary artery anomaly or fistula; or c) the patient will be undergoing non-coronary cardiac surgery (R) (NK) (Anaes.) *(See para DIL and DIQ of explanatory notes to this Category)* **Fee:** $350.00 **Benefit:** 75% = $262.50 85% = $297.50

	GROUP I3 - DIAGNOSTIC RADIOLOGY
	SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES
New 57529	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $14.90 **Benefit:** 75% = $11.20 85% = $12.70
New 57530	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
New 57532	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
New 57533	HAND AND WRIST OR HAND, WRIST AND FOREARM OR FOREARM AND ELBOW OR ELBOW AND HUMERUS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
New 57535	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $16.25 **Benefit:** 75% = $12.20 85% = $13.85
New 57536	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
New 57538	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
New 57539	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.90 **Benefit:** 75% = $24.70 85% = $28.00
	SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS
New 57702	SHOULDER OR SCAPULA (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
New 57705	SHOULDER OR SCAPULA (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
New 57708	CLAVICLE (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $16.25 **Benefit:** 75% = $12.20 85% = $13.85
New 57711	CLAVICLE (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
New 57714	HIP JOINT (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
New 57717	PELVIC GIRDLE (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $30.45 **Benefit:** 75% = $22.85 85% = $25.90
New 57723	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.65 **Benefit:** 75% = $37.25 85% = $42.25

DIAGNOSTIC RADIOLOGY				HEAD
	SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD			
New 57911	SKULL, not in association with item 57902 or 57914 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45	
New 57914	CEPHALOMETRY, not in association with item 57901 or 57911 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45	
New 57917	SINUSES (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.65	**Benefit:** 75% = $17.75	85% = $20.15	
New 57920	MASTOIDS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45	
New 57923	PETROUS TEMPORAL BONES (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45	
New 57926	FACIAL BONES orbit, maxilla or malar, any or all (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10	
New 57929	MANDIBLE, not by orthopantomography technique (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10	
New 57932	SALIVARY CALCULUS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10	
New 57935	NOSE (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10	
New 57938	EYE (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10	
New 57941	TEMPOROMANDIBULAR JOINTS (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15	
New 57944	TEETH SINGLE AREA (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $16.45	**Benefit:** 75% = $12.35	85% = $14.00	
New 57947	TEETH FULL MOUTH (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.15	**Benefit:** 75% = $29.40	85% = $33.30	
New 57950	PALATOPHARYNGEAL STUDIES with fluoroscopic screening (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $32.25	**Benefit:** 75% = $24.20	85% = $27.45	
New 57953	PALATOPHARYNGEAL STUDIES without fluoroscopic screening (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $24.85	**Benefit:** 75% = $18.65	85% = $21.15	
New 57956	LARYNX, LATERAL AIRWAYS AND SOFT TISSUES OF THE NECK, not being a service associated with a service to which item 57939, 57942, 57950 or 57953 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45	

DIAGNOSTIC RADIOLOGY				SPINE
New 57959	Orthopantomography, for diagnosis and/or management of trauma, infection, tumours, congenital conditions or surgical conditions of the teeth or maxillofacial region (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15	
New 57962	Orthopantomography, for diagnosis and/or management of impacted teeth, caries, periodontal or peripical pathology where signs or symptoms of those conditions are evident (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15	
New 57965	Orthopantomography, for diagnosis and/or management of missing or crowded teeth, or developmental anomalies of the teeth or jaws (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15	
New 57968	Orthopantomography, for diagnosis and/or management of temporomandibular joint arthroses or dysfunction (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.70	**Benefit:** 75% = $17.80	85% = $20.15	
	SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE			
New 58102	SPINE CERVICAL (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $33.60	**Benefit:** 75% = $25.20	85% = $28.60	
New 58105	SPINE THORACIC (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.55	**Benefit:** 75% = $20.70	85% = $23.45	
New 58111	SPINE LUMBOSACRAL (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.50	**Benefit:** 75% = $28.90	85% = $32.75	
New 58114	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75	
New 58117	SPINE SACROCOCCYGEAL (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.50	**Benefit:** 75% = $17.65	85% = $20.00	
New 58123	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine, two examinations of the kind referred to in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.65	**Benefit:** 75% = $36.50	85% = $41.40	
New 58124	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106, 58109, 58111 and 58117 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75	
New 58126	Spine, four regions, cervical, thoracic, lumbosacral and sacrococcygeal, if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75	

DIAGNOSTIC RADIOLOGY				BONE AGE STUDY
	NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item			
New 58127	Spine, three examinations of the kind mentioned in items 58100, 58102, 58103, 58105, 58106 and 58109, 58111 and 58117 if the service to which item 58120, 58121, 58126 or 58127 applies has not been performed on the same patient within the same calendar year (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.00	**Benefit:** 75% = $41.25	85% = $46.75	
	SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS			
New 58302	BONE AGE STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $20.05	**Benefit:** 75% = $15.05	85% = $17.05	
New 58308	SKELETAL SURVEY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.70	**Benefit:** 75% = $33.55	85% = $38.00	
	SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION			
New 58502	CHEST (lung fields) by direct radiography (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.70	**Benefit:** 75% = $13.30	85% = $15.05	
New 58505	CHEST (lung fields) by direct radiography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.60	**Benefit:** 75% = $17.70	85% = $20.10	
New 58508	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $30.40	**Benefit:** 75% = $22.80	85% = $25.85	
New 58511	THORACIC INLET OR TRACHEA (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $19.90	**Benefit:** 75% = $14.95	85% = $16.95	
New 58523	LEFT RIBS, RIGHT RIBS OR STERNUM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70	**Benefit:** 75% = $16.30	85% = $18.45	
New 58526	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $28.25	**Benefit:** 75% = $21.20	85% = $24.05	
New 58529	LEFT RIBS, RIGHT RIBS AND STERNUM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $34.70	**Benefit:** 75% = $26.05	85% = $29.50	
	SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT			
New 58702	PLAIN RENAL ONLY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.05	**Benefit:** 75% = $17.30	85% = $19.60	
New 58708	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $78.95	**Benefit:** 75% = $59.25	85% = $67.15	
New 58717	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $75.80	**Benefit:** 75% = $56.85	85% = $64.45	

New 58720	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $63.05 **Benefit:** 75% = $47.30 85% = $53.60
New 58723	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.15 **Benefit:** 75% = $51.90 85% = $58.80
	SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM
New 58902	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915, 58917, 58924 or 58926 applies (NR) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $17.85 **Benefit:** 75% = $13.40 85% = $15.20
New 58905	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58911, 58912, 58914, 58915, 58917, 58924 or 58926 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.80 **Benefit:** 75% = $17.85 85% = $20.25
New 58911	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR DUODENUM, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939, 57942, 57945, 57950, 57953 or 57956 applies - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25
New 58914	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $55.15 **Benefit:** 75% = $41.40 85% = $46.90
New 58917	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $39.50 **Benefit:** 75% = $29.65 85% = $33.60
New 58920	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.25 **Benefit:** 75% = $51.95 85% = $58.90
New 58923	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55
New 58926	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $42.05 **Benefit:** 75% = $31.55 85% = $35.75
New 58929	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
New 58935	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $102.80 **Benefit:** 75% = $77.10 85% = $87.40
New 58938	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30
New 58941	DEFAECOGRAM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25

	SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES
New 59104	Localisation of foreign body, if provided in conjunction with a service described in Subgroups 1 to 12 of Group I3 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $10.65 **Benefit:** 75% = $8.00 85% = $9.10
	SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS
New 59301	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* MAMMOGRAPHY OF BOTH BREASTS, if there is a reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner. Unless otherwise indicated, mammography includes both breasts (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.75 **Benefit:** 75% = $33.60 85% = $38.05
New 59304	MAMMOGRAPHY OF ONE BREAST, if: (a) the patient is referred with a specific request for a unilateral mammogram; and (b) there is reason to suspect the presence of malignancy because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $27.00 **Benefit:** 75% = $20.25 85% = $22.95
New 59307	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $50.15 **Benefit:** 75% = $37.65 85% = $42.65
New 59310	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $100.30 **Benefit:** 75% = $75.25 85% = $85.30
New 59313	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $43.50 **Benefit:** 75% = $32.65 85% = $37.00
New 59315	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $26.25 **Benefit:** 75% = $19.70 85% = $22.35
New 59319	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 31536 - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $23.55 **Benefit:** 75% = $17.70 85% = $20.05
	SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY
New 59504	PELVIMETRY, not being a service associated with a service to which item 57201 or 57247 applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA
New 59701	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $48.30 **Benefit:** 75% = $36.25 85% = $41.10
New 59704	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30

New 59713	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $56.85 **Benefit:** 75% = $42.65 85% = $48.35
New 59716	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05
New 59719	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $67.35 **Benefit:** 75% = $50.55 85% = $57.25
New 59725	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 or 56259 applies - (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.25 **Benefit:** 75% = $84.95 85% = $96.30
New 59734	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 or 57932 applies - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $53.85 **Benefit:** 75% = $40.40 85% = $45.80
New 59737	VASOEPIDIDYMOGRAPHY, 1 side, - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $31.00 **Benefit:** 75% = $23.25 85% = $26.35
New 59740	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40
New 59752	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $69.60 **Benefit:** 75% = $52.20 85% = $59.20
New 59755	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
New 59761	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $57.60 **Benefit:** 75% = $43.20 85% = $49.00
New 59764	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $66.95 **Benefit:** 75% = $50.25 85% = $56.95
	SUBGROUP 14 - TOMOGRAPHY
New 60101	TOMOGRAPHY OF ANY REGION (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $30.40 **Benefit:** 75% = $22.80 85% = $25.85
	SUBGROUP 15 - FLUOROSCOPIC EXAMINATION
New 60501	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $21.70 **Benefit:** 75% = $16.30 85% = $18.45
New 60504	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination) (R) (NK) **Fee:** $14.90 **Benefit:** 75% = $11.20 85% = $12.70

DIAGNOSTIC RADIOLOGY		INTERVENTIONAL TECHNIQUES
New 60507	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) (NK) **Fee:** $31.90 **Benefit:** 75% = $23.95 85% = $27.15	
New 60510	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $49.45 **Benefit:** 75% = $37.10 85% = $42.05	
	SUBGROUP 17 - INTERVENTIONAL TECHNIQUES	
New 61110	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $129.45 **Benefit:** 75% = $97.10 85% = $110.05	

	GROUP I4 - NUCLEAR MEDICINE IMAGING
Amend 61538	FDG PET study of the brain for evaluation of suspected residual or recurrent malignant brain tumour based on anatomical imaging findings, after definitive therapy (or during ongoing chemotherapy) in patients who are considered suitable for further active therapy. (R) **Fee:** $901.00 **Benefit:** 75% = $675.75 85% = $829.80
Amend 61541	Whole body FDG PET study, following initial therapy, for the evaluation of suspected residual, metastatic or recurrent colorectal carcinoma in patients considered suitable for active therapy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
Amend 61553	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected metastatic or recurrent malignant melanoma in patients considered suitable for active therapy (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $927.80
Amend 61565	Whole body FDG PET study, following initial therapy, performed for the evaluation of suspected residual, metastatic or recurrent ovarian carcinoma in patients considered suitable for active therapy. (R) *(See para DIQ of explanatory notes to this Category)* **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
Amend 61571	Whole body FDG PET study, for the further primary staging of patients with histologically proven carcinoma of the uterine cervix, at FIGO stage IB2 or greater by conventional staging, prior to planned radical radiation therapy or combined modality therapy with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
New 61575	Whole body FDG PET study, for the further staging of patients with confirmed local recurrence of carcinoma of the uterine cervix considered suitable for salvage pelvic chemoradiotherapy or pelvic exenteration with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
Amend 61616	Whole body FDG PET study for the initial staging of indolent non–Hodgkin's lymphoma where clinical, pathological and imaging findings indicate that the stage is I or IIA and the proposed management is definitive radiotherapy with curative intent. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
New 61620	Whole body FDG PET study for the initial staging of newly diagnosed or previously untreated Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma. (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
Amend 61622	Whole body FDG PET study to assess response to first line therapy either during treatment or within three months of completing definitive first line treatment for Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma), (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
Amend 61628	Whole body FDG PET study for restaging following confirmation of recurrence of Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma). (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
New 61632	Whole body FDG PET study to assess response to second-line chemotherapy when stem cell transplantation is being considered, for Hodgkin's or non-Hodgkin's lymphoma (excluding indolent non-Hodgkin's lymphoma). (R) **Fee:** $953.00 **Benefit:** 75% = $714.75 85% = $881.80
Amend 61640	Whole body FDG PET study for initial staging of patients with biopsy-proven bone or soft tissue sarcoma (excluding gastrointestinal stromal tumour) considered by conventional staging to be potentially curable. (R) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $927.80
Amend 61646	Whole body FDG PET study for the evaluation of patients with suspected residual or recurrent sarcoma (excluding gastrointestinal stromal tumour) after the initial course of definitive therapy to determine suitability for subsequent therapy with curative intent. (R) **Fee:** $999.00 **Benefit:** 75% = $749.25 85% = $927.80
New 61651	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.45 **Benefit:** 75% = $168.35 85% = $190.80

New 61652	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $282.65 **Benefit:** 75% = $212.00 85% = $240.30
New 61653	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $354.85 **Benefit:** 75% = $266.15 85% = $301.65
New 61654	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $417.45 **Benefit:** 75% = $313.10 85% = $354.85
New 61655	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $183.65 **Benefit:** 75% = $137.75 85% = $156.15
New 61656	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $151.70 **Benefit:** 75% = $113.80 85% = $128.95
New 61657	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $178.50
New 61658	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.60 **Benefit:** 75% = $142.95 85% = $162.05
New 61659	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.20 **Benefit:** 75% = $184.65 85% = $209.30
New 61660	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $114.45 **Benefit:** 75% = $85.85 85% = $97.30
New 61661	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.85 **Benefit:** 75% = $85.40 85% = $96.80
New 61662	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.50 **Benefit:** 75% = $94.90 85% = $107.55
New 61663	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $221.70 **Benefit:** 75% = $166.30 85% = $188.45
New 61664	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $129.70 **Benefit:** 75% = $97.30 85% = $110.25

New 61665	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $193.30	**Benefit:** 75% = $145.00	85% = $164.35
New 61666	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $196.40	**Benefit:** 75% = $147.30	85% = $166.95
New 61667	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.70	**Benefit:** 75% = $151.30	85% = $171.45
New 61668	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $230.70	**Benefit:** 75% = $173.05	85% = $196.10
New 61669	BOWEL HAEMORRHAGE STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $248.50	**Benefit:** 75% = $186.40	85% = $211.25
New 61670	MECKEL'S DIVERTICULUM STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.55	**Benefit:** 75% = $83.70	85% = $94.85
New 61671	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (Ministerial Determination) (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $1,007.90	**Benefit:** 75% = $755.95	85% = $936.70
New 61672	SALIVARY STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.55	**Benefit:** 75% = $83.70	85% = $94.85
New 61673	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $244.85	**Benefit:** 75% = $183.65	85% = $208.15
New 61674	OESOPHAGEAL CLEARANCE STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $71.70	**Benefit:** 75% = $53.80	85% = $60.95
New 61675	GASTRIC EMPTYING STUDY, using single tracer (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $287.20	**Benefit:** 75% = $215.40	85% = $244.15
New 61676	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $312.50	**Benefit:** 75% = $234.40	85% = $265.65
New 61677	RADIONUCLIDE COLONIC TRANSIT STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $343.85	**Benefit:** 75% = $257.90	85% = $292.30
New 61678	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $166.25	**Benefit:** 75% = $124.70	85% = $141.35

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING
New 61679	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $215.40 **Benefit:** 75% = $161.55 85% = $183.10	
New 61680	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $185.30 **Benefit:** 75% = $139.00 85% = $157.55	
New 61681	RENAL STUDY with diuretic administration following a baseline study (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $205.00 **Benefit:** 75% = $153.75 85% = $174.25	
New 61682	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $302.75 **Benefit:** 75% = $227.10 85% = $257.35	
New 61683	CYSTOURETEROGRAM (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $123.45 **Benefit:** 75% = $92.60 85% = $104.95	
New 61684	TESTICULAR STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $81.15 **Benefit:** 75% = $60.90 85% = $69.00	
New 61685	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $302.55 **Benefit:** 75% = $226.95 85% = $257.20	
New 61686	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $173.00 **Benefit:** 75% = $129.75 85% = $147.05	
New 61687	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $436.75 **Benefit:** 75% = $327.60 85% = $371.25	
New 61688	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $113.00 **Benefit:** 75% = $84.75 85% = $96.05	
New 61689	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $59.45 **Benefit:** 75% = $44.60 85% = $50.55	
New 61690	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $239.90 **Benefit:** 75% = $179.95 85% = $203.95	
New 61691	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $300.35 **Benefit:** 75% = $225.30 85% = $255.30	
New 61692	WHOLE BODY STUDY using iodine (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $277.40 **Benefit:** 75% = $208.05 85% = $235.80	
New 61693	WHOLE BODY STUDY using gallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $271.50 **Benefit:** 75% = $203.65 85% = $230.80	

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING
New 61694	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $329.75 **Benefit:** 75% = $247.35 85% = $280.30	
New 61695	WHOLE BODY STUDY using cells labelled with technetium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $248.50 **Benefit:** 75% = $186.40 85% = $211.25	
New 61696	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $307.70 **Benefit:** 75% = $230.80 85% = $261.55	
New 61697	WHOLE BODY STUDY using thallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $271.40 **Benefit:** 75% = $203.55 85% = $230.70	
New 61698	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $336.50 **Benefit:** 75% = $252.40 85% = $286.05	
New 61699	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $244.85 **Benefit:** 75% = $183.65 85% = $208.15	
New 61700	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $376.20 **Benefit:** 75% = $282.15 85% = $319.80	
New 61701	BONE MARROW STUDY - localised using technetium labelled agent (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $143.40 **Benefit:** 75% = $107.55 85% = $121.90	
New 61702	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $166.80 **Benefit:** 75% = $125.10 85% = $141.80	
New 61703	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $228.10 **Benefit:** 75% = $171.10 85% = $193.90	
New 61704	LOCALISED STUDY using gallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $198.80 **Benefit:** 75% = $149.10 85% = $169.00	
New 61705	LOCALISED STUDY using gallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $257.35 **Benefit:** 75% = $193.05 85% = $218.75	
New 61706	LOCALISED STUDY using cells labelled with technetium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95	
New 61707	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $235.25 **Benefit:** 75% = $176.45 85% = $200.00	
New 61708	LOCALISED STUDY using thallium (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $198.50 **Benefit:** 75% = $148.90 85% = $168.75	
New 61709	LOCALISED STUDY using thallium, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $263.95 **Benefit:** 75% = $198.00 85% = $224.40	

NUCLEAR MEDICINE IMAGING			NUCLEAR MEDICINE IMAGING
New 61710	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453, 61469, 61484, 61485, 61669, 61692, 61693, 61694, 61700, 61704, 61705, 61712, 61715 or 61716 where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $64.50	**Benefit:** 75% = $48.40	85% = $54.85
New 61711	VENOGRAPHY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $132.75	**Benefit:** 75% = $99.60	85% = $112.85
New 61712	LYMPHOSCINTIGRAPHY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $174.05	**Benefit:** 75% = $130.55	85% = $147.95
New 61713	THYROID STUDY including uptake measurement when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $87.70	**Benefit:** 75% = $65.80	85% = $74.55
New 61714	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $193.45	**Benefit:** 75% = $145.10	85% = $164.45
New 61715	ADRENAL STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $440.45	**Benefit:** 75% = $330.35	85% = $374.40
New 61716	ADRENAL STUDY, with single photon emission tomography (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $499.60	**Benefit:** 75% = $374.70	85% = $428.40
New 61717	TEAR DUCT STUDY (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $111.55	**Benefit:** 75% = $83.70	85% = $94.85
New 61718	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $126.50	**Benefit:** 75% = $94.90	85% = $107.55
New 61719	CT scan performed at the same time and covering the same body area as single photon emission tomography for the purpose of anatomic localisation or attenuation correction where no separate diagnostic CT report is issued and only in association with items 61302 - 61729 (R) (NK) *(See para DIQ of explanatory notes to this Category)* **Fee:** $50.00	**Benefit:** 75% = $37.50	85% = $42.50
New 61729	LEUKOSCAN STUDY, for use in diagnostic imaging of the long bones and feet in patients with suspected osteomyelitis, and where patients do not have access to ex-vivo WBC scanning. (Ministerial Determination) (NK) Note LeukoScan is only indicated for diagnostic imaging in patients suspected of infection in the long bones and feet, including those with diabetic ulcers. The descriptor does not cover patients who are being investigated for other sites of infection *(See para DIQ of explanatory notes to this Category)* **Fee:** $439.35	**Benefit:** 75% = $329.55	85% = $373.45

	GROUP I5 - MAGNETIC RESONANCE IMAGING
	SUBGROUP 1 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS
New 63013	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for: - tumour of the brain or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63014	- inflammation of the brain or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63016	- skull base or orbital tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63017	- stereotactic scan of brain, with Fiducials in place, for the sole purpose to allow planning for stereotactic neurosurgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
	SUBGROUP 2 - SCAN OF HEAD - FOR SPECIFIED CONDITIONS
New 63074	**NOTE: Benefits are payable for each service included by Subgroup 2 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head** for: - acoustic neuroma (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
New 63075	- pituitary tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35
New 63076	- toxic or metabolic or ischaemic encephalopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63077	- demyelinating disease of the brain (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63078	- congenital malformation of the brain or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63079	- venous sinus thrombosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63080	- head trauma (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63081	- epilepsy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

MAGNETIC RESONANCE IMAGING		MRI
New 63082	- stroke (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40	
New 63083	- carotid or vertebral artery desection (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40	
New 63084	- intracranial aneurysm (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40	
New 63085	- intracranial arteriovenous malformation (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40	
	SUBGROUP 3 - SCAN OF HEAD AND NECK VESSELS - FOR SPECIFIED CONDITIONS	
New 63104	**NOTE: Benefits are payable for each service included by Subgroup 3 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING AND MAGNETIC RESONANCE ANGIOGRAPHY of extra and/or intracranial circulation, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and neck vessels** for: - stroke (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45	
New 63117	MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - tumour of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45	
New 63119	- inflammation of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45	
	SUBGROUP 5 - SCAN OF HEAD AND CERVICAL SPINE - FOR SPECIFIED CONDITIONS	
New 63134	**NOTE: Benefits are payable for each service included by Subgroup 5 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of head and cervical spine** for: - demyelinating disease of the central nervous system (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45	
New 63135	- congenital malformation of the central nervous system or meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45	
New 63136	- syrinx (congenital or aquired) (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40 **Benefit:** 75% = $184.80 85% = $209.45	

MAGNETIC RESONANCE IMAGING		MRI
	SUBGROUP 6 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS	
New 63157	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - infection (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63158	- tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
	SUBGROUP 7 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS	
New 63186	**NOTE: Benefits are payable for each service included by Subgroup 7 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of one region or two contiguous regions of the spine** for: - demyelinating (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63187	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63188	- myelopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63189	- syrinx (congenital or aquired) (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63190	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63191	- sciatica (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63192	- spinal canal stenosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63193	- previous spinal surgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	
New 63194	- trauma (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35	

MAGNETIC RESONANCE IMAGING		MRI
	SUBGROUP 8 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS	
New 63207	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - infection (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63208	- tumour (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
	SUBGROUP 9 - SCAN OF SPINE - THREE CONTIGUOUS REGIONS OR TWO NON-CONTIGUOUS REGIONS - FOR SPECIFIED CONDITIONS	
New 63257	**NOTE: Benefits are payable for each service included by Subgroup 9 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of three contiguous regions or two non contiguous regions of the spine** for: - demyelinating disease (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63258	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63259	- myelopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63260	- syrinx (congenital or aquired) (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63261	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63262	- sciatica (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63263	- spinal canal stenosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63264	- previous spinal surgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	
New 63265	- trauma (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40	

MAGNETIC RESONANCE IMAGING		MRI
	SUBGROUP 10 - SCAN OF CERVICAL SPINE AND BRACHIAL PLEXUS - FOR SPECIFIED CONDITIONS	
	NOTE: Benefits are payable for each service included by Subgroup 10 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cervical spine and brachial plexus** for: - tumour (R) (NK) (Contrast) (Anaes.)	
New 63282	*(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40	**Benefit:** 75% = $184.80 85% = $209.45
New 63283	- trauma (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40	**Benefit:** 75% = $184.80 85% = $209.45
New 63284	- cervical radiculopathy (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40	**Benefit:** 75% = $184.80 85% = $209.45
New 63285	- previous surgery (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $246.40	**Benefit:** 75% = $184.80 85% = $209.45
	SUBGROUP 11 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS	
	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - tumour arising in bone or musculoskeletal system, this excludes tumours arising in breast, prostate or rectum (R) (NK) (Contrast) (Anaes.)	
New 63310	*(See para DIQ of explanatory notes to this Category)* **Fee:** $190.40	**Benefit:** 75% = $142.80 85% = $161.85
New 63311	- infection arising in bone or musculoskeletal system, this excludes infection arising in breast, prostate or rectum (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.40	**Benefit:** 75% = $142.80 85% = $161.85
New 63313	- osteonecrosis (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $190.40	**Benefit:** 75% = $142.80 85% = $161.85
	SUBGROUP 12 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS	
	NOTE: Benefits are payable for each service included by Subgroup 12 on three occasions only in any 12 month period MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - derangement of hip or its supporting structures (R) (NK) (Contrast) (Anaes.)	
New 63341	*(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20 85% = $171.40
New 63342	- derangement of shoulder or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20 85% = $171.40
New 63343	- derangement of knee or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20 85% = $171.40
New 63345	- derangement of ankle and/or foot or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60	**Benefit:** 75% = $151.20 85% = $171.40

New 63346	- derangement of one or both temporomandibular joints or their supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
New 63347	- derangement of wrist and/or hand or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
New 63348	- derangement of elbow or its supporting structures (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 13 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR SPECIFIED CONDITIONS
New 63364	**NOTE: Benefits are payable for each service included by Subgroup 13 on two occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of musculoskeletal system** for: - Gaucher disease (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 14 - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
New 63392	**NOTE: Benefits are payable for each service included by Subgroup 14 on two occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of cardiovascular system** for: - congenital disease of the heart or a great vessel (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
New 63393	- tumour of the heart or a great vessel (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $224.00 **Benefit:** 75% = $168.00 85% = $190.40
New 63394	- abnormality of thoracic aorta (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 15 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR SPECIFIED CONDITIONS
New 63407	**NOTE: Benefits are payable for each service included by Subgroup 15 on three occasions only in any 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for: - vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63408	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

	SUBGROUP 16 - MAGNETIC RESONANCE ANGIOGRAPHY - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
New 63419	**NOTE: Benefits are payable for each service included by Subgroup 16 on one occasion only in any 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 17 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
New 63432	**NOTE: Benefits are payable for each service included by Subgroup 17 on two occasions only in any 12 month period, for previously diagnosed conditions** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - post-inflammatory or post-traumatic physeal fusion (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63433	- Gaucher disease (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 18 - MAGNETIC RESONANCE IMAGING - FOR SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
New 63447	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of person under the age of 16** for: - pelvic or abdominal mass (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63448	- mediastinal mass (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63449	- congenital uterine or anorectal abnormality (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 19 - SCAN OF BODY - FOR SPECIFIED CONDITIONS
New 63455	**NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of body** for: - adrenal mass in a patient with malignancy which is otherwise resectable (R) (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $179.20 **Benefit:** 75% = $134.40 85% = $152.35

MAGNETIC RESONANCE IMAGING	MRI
New 63457	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the request for scan identifies that the woman is asymptomatic and is less than 50 years of age; and (c) the request for scan identifies either: (i) that the patient is at high risk of developing breast cancer, due to 1 of the following: (A) 3 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer; (B) 2 or more first or second degree relatives on the same side of the family diagnosed with breast or ovarian cancer, if any of the following applies to at least 1 of the relatives: - has been diagnosed with bilateral breast cancer; - had onset of breast cancer before the age of 40 years; - had onset of ovarian cancer before the age of 50 years; - has been diagnosed with breast and ovarian cancer, at the same time or at different times; - has Ashkenazi Jewish ancestry; - is a male relative who has been diagnosed with breast cancer; (C) 1 first or second degree relative diagnosed with breast cancer at age 45 years or younger, plus another first or second degree relative on the same side of the family with bone or soft tissue sarcoma at age 45 years or younger; or (ii) that genetic testing has identified the presence of a high risk breast cancer gene mutation. **Scan of both breasts** for: - detection of cancer (R) **NOTE: Benefits are payable on one occasion only in any 12 month period** (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25
New 63458	MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a dedicated breast coil is used; and (b) the woman has had an abnormality detected as a result of a service described in item 63464 or 63457 performed in the previous 12 months **Scan of both breasts for:** - detection of cancer (R) **NOTE 1: Benefits are payable on one occasion only in any 12 month period** **NOTE 2: This item is intended for follow-up imaging of abnormalities diagnosed on a scan described by item 63464 or 63457** (NK) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $293.25
	SUBGROUP 20 - SCAN OF PELVIS AND UPPER ABDOMEN - FOR SPECIFIED CONDITIONS
New 63479	**NOTE: Benefits are payable for a service included by Subgroup 20 on one occasion only.** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where: (a) the patient is referred by a specialist or by a consultant physician and (b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater Scan of: - Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
New 63481	- Pelvis and upper abdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $313.60 **Benefit:** 75% = $235.20 85% = $266.60

MAGNETIC RESONANCE IMAGING	MRI
New 63484	**NOTE: benefits are payable for a service included by Subgroup 20 on one occasion only.** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where: (a) a phased array body coil is used, and (b) the request for scan identifies that the indication is for the initial staging of rectal cancer (including cancer of the rectosigmoid and anorectum). Scan of: - Pelvis for the initial staging of rectal cancer (R) (NK) (contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40
	SUBGROUP 21 - SCAN OF BODY - FOR SPECIFIED CONDITIONS
New 63486	**NOTE: Benefits are only payable for each service included by Subgroup 21 on three occasions only in any 12 month period** MAGNETIC RESONANCE IMAGING performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician - **scan of pancreas and biliary tree** for: - suspected biliary or pancreatic pathology (R) (NK) (Contrast) (Anaes.) *(See para DIQ of explanatory notes to this Category)* **Fee:** $201.60 **Benefit:** 75% = $151.20 85% = $171.40

	GROUP P2 - CHEMICAL
Amend 66605	Vitamins - quantitation of vitamins B1, B2, B3, B6 or C in blood, urine or other body fluid - 1 or more tests **Fee:** $30.80 **Benefit:** 75% = $23.10 85% = $26.20
Amend 66607	Vitamins - quantitation of vitamins A or E in blood, urine or other body fluid - 1 or more tests within a 6 month period **Fee:** $76.25 **Benefit:** 75% = $57.20 85% = $64.85
New 66610	A test described in item 66607 if rendered by a receiving APP - 1 or more tests **Fee:** $76.25 **Benefit:** 75% = $57.20 85% = $64.85
Fee 66659	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the followup of a PSA result that lies at or above the age related median but below the age related, method specific 97.5% reference limit - 1 of this item in a 12 month period (Item is subject to rule 25) **Fee:** $37.55 **Benefit:** 75% = $28.20 85% = $31.95
Fee 66660	Prostate specific antigen – quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656, in the follow up of a PSA result that lies at or above the age related, method specific 97.5% reference limit, but below a value of 10 ug/L – 4 of this item in a 12 month period. (Item is subject to rule 25) **Fee:** $37.55 **Benefit:** 75% = $28.20 85% = $31.95
	GROUP P3 - MICROBIOLOGY
Amend 69333	Urine examination (including serial examination) by any means other than simple culture by dip slide, including: (a) cell count; and (b) culture; and (c) colony count; and (d) (if performed) stained preparations; and (e) (if performed) identification of cultured pathogens; and (f) (if performed) antibiotic suseptibility testing; and (g) (if performed) examination for pH, specific gravity, blood, protein, urobilinogen, sugar, acetone or bile salts **Fee:** $20.70 **Benefit:** 75% = $15.55 85% = $17.60
New 69380	Genotypic testing for HIV antiretroviral resistance in a patient with confirmed HIV infection if the patient's viral load is greater than 1,000 copies per ml at any of the following times: a. at presentation; or b. before antiretroviral therapy: or c. when treatment with combination antiretroviral agents fails; maximum of 2 tests in a 12 month period **Fee:** $775.50 **Benefit:** 75% = $581.65 85% = $704.30
	GROUP P4 - IMMUNOLOGY
Fee 71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes; or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15
Amend **Fee** 71059	Immunofixation or immunoelectrophoresis or isoelectric focusing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation of a paraprotein or cryoglobulin - examination of 1 specimen type (eg. serum, urine or CSF) **Fee:** $35.90 **Benefit:** 75% = $26.95 85% = $30.55
Fee 71200	Detection and quantitation, if present, of free kappa and lambda light chains in serum for the diagnosis or monitoring of amyloidosis, myeloma or plasma cell dyscrasias. **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00

	GROUP P6 - CYTOLOGY
Amend 73051	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance **Fee:** $171.50 **Benefit:** 75% = $128.65 85% = $145.80
Amend 73063	Cytology of material obtained directly from a patient at one identified site by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
New 73066	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if a recognized pathologist: (a) performs the aspiration; or (b) attends the aspiration and performs cytological examination during the attendance **Fee:** $222.95 **Benefit:** 75% = $167.25 85% = $189.55
New 73067	Cytology of material obtained directly from a patient at 2 or more separately identified sites by fine needle aspiration of solid tissue or tissues if an employee of an approved pathology authority attends the aspiration for confirmation of sample adequacy **Fee:** $130.00 **Benefit:** 75% = $97.50 85% = $110.50
	GROUP P7 - GENETICS
New 73325	Characterisation of mutations in: (a) the JAK2 gene; or (b) the MPL gene; or (c) both genes; in the diagnostic work-up, by, or on behalf of, the specialist or consultant physician, of a patient with clinical and laboratory evidence of: a) polycythaemia vera; or b) essential thrombocythaemia; 1 or more tests **Fee:** $75.00 **Benefit:** 75% = $56.25 85% = $63.75
New 73326	Characterisation of the gene rearrangement FIP1L1-PDGFRA in the diagnostic work-up and management of a patient with laboratory evidence of: a) mast cell disease; or b) idiopathic hypereosinophilic syndrome; or c) chronic eosinophilic leukaemia;. 1 or more tests **Fee:** $232.50 **Benefit:** 75% = $174.40 85% = $197.65
New 73327	Detection of genetic polymorphisms in the Thiopurine S-methyltransferase gene for the prevention of dose-related toxicity during treatment with thiopurine drugs; including (if performed) any service described in item 65075. 1 or more tests **Fee:** $52.30 **Benefit:** 75% = $39.25 85% = $44.50

MISCELLANEOUS	TELEHEALTH SUPPORT SERVICE
	GROUP M12 - SERVICES PROVIDED BY A PRACTICE NURSE OR REGISTERED ABORIGINAL HEALTH WORKER ON BEHALF OF A MEDICAL PRACTITIONER
	SUBGROUP 1 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER
New 10983	Service by a practice nurse or Aboriginal health worker provided on behalf of, and under the supervision of, a medical practitioner that requires the provision of clinical support to a patient who is: a) located at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; or b) located outside an inner metropolitan area, not being an admitted patient; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $31.20 **Benefit:** 100% = $31.20
	SUBGROUP 2 - TELEHEALTH SUPPORT SERVICE ON BEHALF OF A MEDICAL PRACTITIONER AT A RESIDENTIAL AGED CARE FACILITY
New 10984	Service by a practice nurse or Aboriginal health worker provided on behalf of, and under the supervision of, a medical practitioner that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a self-contained unit); or b) at consulting rooms situated within such a complex if the patient is a care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $31.20 **Benefit:** 100% = $31.20

	GROUP M10 - AUTISM, PERVASIVE DEVELOPMENTAL DISORDER AND DISABILITY SERVICES
Amend 82000	**PSYCHOLOGY** Psychology health service provided to a child, aged under 13 years, by an eligible psychologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $96.00 **Benefit:** 85% = $81.60
Amend 82005	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 13 years, by an eligible speech pathologist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner: and (d) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $84.60 **Benefit:** 85% = $71.95
Amend 82010	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 13 years, by an eligible occupational therapist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items ─ 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $84.60 **Benefit:** 85% = $71.95

Amend 82015	**PSYCHOLOGY** Psychology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible psychologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the psychologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items – 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $96.00 **Benefit:** 85% = $81.60
Amend 82020	**SPEECH PATHOLOGY** Speech pathology health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible speech pathologist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the speech pathologist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items – 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $84.60 **Benefit:** 85% = $71.95
Amend 82025	**OCCUPATIONAL THERAPY** Occupational therapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or an eligible disability by an eligible occupational therapist where: (a) the child has been diagnosed with PDD or an eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the occupational therapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items – 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $84.60 **Benefit:** 85% = $71.95

New 82030	**AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY** Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 13 years, by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child is referred by an eligible practitioner for the purpose of assisting the practitioner with their diagnosis of the child; or (b) the child is referred by an eligible practitioner for the purpose of contributing to the child's pervasive developmental disorder (PDD) or disability treatment plan, developed by the practitioner; and (c) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (d) the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (e) the child is not an admitted patient of a hospital; and (f) the service is provided to the child individually and in person; and (g) the service lasts at least 50 minutes in duration. These items are limited to a maximum of four services per patient, consisting of any combination of the following items - 82000, 82005, 82010 and 82030 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $84.60 **Benefit:** 85% = $71.95
New 82035	**AUDIOLOGY, OPTOMETRY, ORTHOPTIC OR PHYSIOTHERAPY** Audiology, optometry, orthoptic or physiotherapy health service provided to a child, aged under 15 years, for treatment of a pervasive developmental disorder (PDD) or eligible disability by an eligible audiologist, optometrist, orthoptist or physiotherapist where: (a) the child has been diagnosed with PDD or eligible disability; and (b) the child has received a PDD or disability treatment plan (while aged under 13 years) as prepared by an eligible practitioner; and (c) the child has been referred by an eligible practitioner for the provision of services that are consistent with the PDD or disability treatment plan; and (d) for a child with PDD, the eligible practitioner is a consultant physician in the practice of his or her field of psychiatry or paediatrics; or for a child with disability, the eligible practitioner is a specialist, consultant physician or general practitioner; and (e) the audiologist, optometrist, orthoptist or physiotherapist attending the child is registered with Medicare Australia as meeting the credentialing requirements for provision of these services; and (f) the child is not an admitted patient of a hospital; and (g) the service is provided to the child individually and in person; and (h) the service lasts at least 30 minutes in duration. These items are limited to a maximum of 20 services per patient, consisting of any combination of items - 82015, 82020, 82025 and 82035 *(See para M10.1 of explanatory notes to this Category)* **Fee:** $84.60 **Benefit:** 85% = $71.95

	GROUP M13 - MIDWIFERY SERVICES
	SUBGROUP 2 - TELEHEALTH ATTENDANCES
New 82150	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist practising in their specialty of obstetrics or paediatrics. **Fee:** $27.20 **Benefit:** 85% = $23.15
New 82151	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist practising in their specialty of obstetrics or paediatrics. **Fee:** $51.65 **Benefit:** 85% = $43.95
New 82152	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating midwife that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist practising in their specialty of obstetrics or paediatrics. **Fee:** $76.00 **Benefit:** 85% = $64.60

	GROUP M14 - NURSE PRACTITIONERS
	SUBGROUP 2 - TELEHEALTH ATTENDANCE
New 82220	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $27.20 **Benefit:** 85% = $23.15
New 82221	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $51.65 **Benefit:** 85% = $43.95
New 82222	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who is: a) located outside an inner metropolitan area, not being an admitted patient; or b) at an Aboriginal Medical Service or Aboriginal Community Controlled Health Service in relation to which a direction made under subsection 19(2) of the Act applies; and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $76.00 **Benefit:** 85% = $64.60
	SUBGROUP 3 - TELEHEALTH ATTENDANCE AT A RESIDENTIAL AGED CARE FACILITY
New 82223	A professional attendance lasting less than 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex if the patient is an approved care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $27.20 **Benefit:** 85% = $23.15
New 82224	A professional attendance lasting at least 20 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex if the patient is an approved care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician. **Fee:** $51.65 **Benefit:** 85% = $43.95
New 82225	A professional attendance lasting at least 40 minutes (whether or not continuous) by a participating nurse practitioner that requires the provision of clinical support to a patient who is: a) a care recipient receiving care in a residential aged care service (other than a professional attendance at a self-contained unit); or b) at consulting rooms situated within such a complex if the patient is an approved care recipient receiving care in a residential aged care service (excluding accommodation in a self-contained unit); and who is participating in a video consultation with a specialist or consultant physician **Fee:** $76.00 **Benefit:** 85% = $64.60