Commonwealth Department of
Community Services and Health

Supplement No. 2 to

Medicare Benefits Schedule Book

of 1 May 1990

Effective–1 May 1991

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SUPPLEMENT (NO 2) TO 1 MAY 1990
MEDICARE BENEFITS SCHEDULE BOOK
AMENDMENTS - EFFECTIVE 1 MAY 1991

Amendments incorporated in this supplement to the Medicare Benefits Schedule include:

. a separate diagnostic imaging services schedule

. changes resulting from consultations between professional groups and the Commonwealth involving services applying to:

- vascular surgery
- neurosurgery
- plastic and reconstructive surgery

The amendments apply to services rendered on and after 1 May 1991.

2. The creation of a separate Diagnostic Imaging Services Schedule (similar to that for pathology services) brings together all diagnostic imaging services currently spread throughout various parts of the General Medical Services Schedule. The amendments also involve substantial changes to the arrangements under which diagnostic imaging services will attract Medicare benefits. Details of these new arrangements are at Appendix C, together with the new Schedule of Diagnostic Imaging Services. These notes should be read in conjunction with the general notes contained in the front of the current (1/5/90) edition of the Medicare Benefits Schedule book.

3. Existing item numbers for the various categories of diagnostic imaging services have been retained pending a restructure of the format of the current parts and divisions of the Schedule and the introduction of a five digit item numbering system expected to be operative from 1 November 1991.

4. The reviews of vascular surgery, neurosurgery and plastic and reconstructive surgery sections of the General Medical Services Schedule involve the introduction of new items; amendments to descriptions and/or Schedule fees for a number of items; and the cessation of some items. Although some of the items included in these sections have not been amended in any way, the sections have been reprinted in full in this supplement for ease of reference.

5. Due to the number of new services incorporated into the vascular surgery section it has been necessary to renumber services in adjacent areas of the Schedule. Items renumbered are - 4622 which is now 4618, 4630 which becomes 4619 and 4832 which becomes 4837. For the same reason a number of services in Division 13 (Plastic and Reconstructive Surgery) have been located out of anatomical sequence, for example, Items 8688 to 8698 relating to free grafting to burns. However, this is only a temporary measure and the items will be relocated at the next reprint.

6. The abovementioned reviews have also involved the transfer of services from one division or part to another with items being renumbered. A list of such transfers is as follows (the new item number is shown in brackets):

ITEM NO.	TRANSFERRED FROM				TO			
924 (4793)	Part	6			Part 10,		Division	1
4695 (8519)	Part	10,	Div.	1	"	"	"	13
4756 (8521)	"	"	"	"	"	"	"	"
4764 (8523)	"	"	"	"	"	"	"	"
4806 (7015)	"	"	"	"	"	"	"	7
4829 (7091)	"	"	"	"	"	"	"	8
4830 (7093)	"	"	"	"	"	"	"	"
7376 (4820)	"	"	"	8	"	"	"	1
7793 (7197)	"	"	"	10	"	"	"	8
7798 (7199)	"	"	"	"	"	"	"	"
7945 (7211)	"	"	"	11	"	"	"	"
7947 (7195)	"	"	"	"	"	"	"	"
7957 (7213)	"	"	"	"	"	"	"	"
7961 (7214)	"	"	"	"	"	"	"	"
7967 (7208)	"	"	"	"	"	"	"	"
7969 (7209)	"	"	"	"	"	"	"	"
8158 (4761)	"	"	"	"	"	"	"	1
8159 (4760)	"	"	"	"	"	"	"	"
8161 (4759)	"	"	"	"	"	"	"	"
8442 (7167)	"	"	"	12	"	"	"	8
8444 (7168)	"	"	"	"	"	"	"	"

7. As a result of the review of neurosurgery services an amendment has been made to Items 5108/5112 by the inclusion of "retromastoid" approach (see Appendix A).

8. As indicated above the sections of the Schedule relating to vascular surgery, neurosurgery and plastic and reconstructive surgery have been reproduced in full in this supplement and are attached at Appendix A. Details of Schedule fees and Medicare benefit levels have been colocated with item descriptions in the amendment pages. This feature will be common to all items when the MBS book is next reprinted.

SUMMARY OF CHANGES

9. Details of new items, ceased items and amendments to existing item numbers and descriptions of services are summarised below. A conversion list of services where items have been renumbered or split into several items is at Appendix B.

CEASED ITEMS

10. The following items have been deleted from the Schedule.

4693	4696	4699	4702	4705	4709	4715	4733	4754	4755	4762
4778	4791	4794	4798	4801	4817	4825	7118	7119	7124	7132
7139	8470	8472	8509	8510	8511	8634	8636	8652		

NEW ITEMS

11. The following new items have been introduced into the Schedule.

4626	4631	4634	4636	4638	4640	4643	4644	4645	4646	4647
4648	4650	4652	4653	4654	4656	4657	4659	4660	4661	4663
4666	4667	4668	4669	4671	4672	4673	4674	4675	4676	4677

4678	4679	4680	4681	4682	4683	4684	4685	4686	4687	4689
4691	4692	4694	4697	4698	4700	4701	4703	4704	4706	4707
4708	4710	4711	4712	4713	4714	4716	4717	4718	4720	4722
4723	4725	4726	4728	4729	4730	4731	4732	4734	4735	4736
4737	4739	4740	4741	4742	4747	4748	4750	4751	4752	4753
4757	4758	4763	4767	4768	4769	4770	4771	4772	4773	4775
4776	4779	4781	4782	4783	4785	4790	4795	4796	4799	4804
4805	4807	4809	4810	4811	4815	4816	4818	4820	4821	4826
4827	4828	4831	4834	7076	7086	7088	7108	7109	7116	7137
7149	7151	7154	7164	7165	7166	7169	7172	7173	7185	7187
7196	7217	7223	7224	7225	7226	7227	7228	8445	8446	8447
8451	8471	8473	8475	8483	8515	8517	8525	8526	8527	8529
8539	8545	8549	8550	8557	8599	8623	8625	8627	8631	8633
8655	8657	8674	8684	8685	8686	8687	8688	8689	8690	8691
8692	8693	8694	8695	8696	8697	8698	8699			

ITEMS RE-NUMBERED

12. The following items have been renumbered.

OLD	NEW	OLD	NEW	OLD	NEW	OLD	NEW
924	4793	4829	7091	7216	7111	7947	7195
4622	4618	4830	7093	7231	7112	7957	7213
4630	4619	4832	4837	7240	7113	7961	7214
4633	4620	7079	7077	7244	7114	7967	7208
4637	4621	7081	7078	7248	7115	7969	7209
4641	4624	7085	7070	7251	7219	8158	4761
4649	4625	7089	7071	7265	7136	8159	4760
4651	4623	7099	7072	7270	7147	8161	4759
4655	4627	7120	7095	7274	7150	8442	7167
4658	4628	7121	7096	7279	7135	8444	7168
4662	4629	7129	7097	7283	7158	8450	8453
4664	4632	7133	7100	7287	7155	8452	8455
4665	4803	7138	7098	7291	7159	8454	8456
4688	4746	7140	7102	7298	7229	8474	8467
4690	4743	7141	7101	7314	7160	8484	8481
4695	8519	7143	7103	7316	7161	8535	8541
4721	4797	7148	7104	7318	7163	8601	8605
4738	4719	7152	7104	7320	7162	3004(153)	4765
4744	4639	7153	7084	7324	7174	3004(160)	7218
4749	4642	7156	7105	7326	7176	3004(161)	7222
4756	8521	7157	7082	7328	7130	3004(186)	7090
4764	8523	7170	7080	7331	7177	3004(190)	7094
4766	4819	7171	7083	7336	7179	3004(244)	7092
4784	4724	7175	7107	7338	7180	3004(255)	7232
4789	4727	7178	7106	7341	7181		
4792	4670	7182	7106	7353	7188		
4802	4774	7184	7073	7355	7189		
4806	7015	7186	7074	7361	7191		
4808	4777	7190	7075	7365	7193		
4812	4780	7192	7117	7370	7183		
4813	4835	7194	7122	7373	7200		
4814	4836	7198	7123	7381	7087		
4822	4786	7203	7125	7793	7197		
4823	4787	7204	7126	7798	7199		
4824	4788	7212	7110	7945	7211		

AMENDED DESCRIPTIONS

13. The descriptions of the following items have been amended.

4624	4625	4627	4629	4632	4639	4642	4670	4719	4724	4727
4743	4746	4760	4761	4765	4774	4786	4788	4793	4797	4803
4819	5108	5112	7070	7075	7077	7080	7082	7083	7090	7091
7092	7093	7094	7095	7096	7097	7098	7100	7101	7102	7106
7107	7112	7114	7117	7125	7126	7130	7136	7147	7150	7159
7161	7162	7163	7167	7168	7177	7179	7180	7181	7188	7189
7197	7199	7218	7219	7222	7229	8448	8449	8453	8455	8458
8462	8466	8467	8476	8478	8480	8481	8496	8502	8504	8508
8512	8516	8518	8519	8521	8522	8523	8524	8530	8531	8532
8534	8540	8544	8548	8552	8553	8554	8556	8560	8582	8584
8585	8586	8594	8600	8604	8614	8622	8624	8628	8630	8632
8640	8644	8656	8658	8660	8662	8664	8666	8668	8670	8672
8677	8678	8679	8680	8682	8683					

AMENDED ANAESTHETIC UNITS

14. The anaesthetic units of the following items have been amended.

4639	4642	4719	4724	4727	4743	4746	4759	4761	4765	4774
4786	4788	4793	4797	4803	4819	8486	8487	8488	8538	8554
8556										

AMENDED FEES

15. The fees of the following items have been amended:-

4624	4625	4629	4632	4639	4642	4670	4719	4724	4727	4743
4746	4759	4760	4761	4765	4774	4777	4780	4786	4787	4788
4793	4797	4803	4819	7072	7073	7074	7077	7078	7084	7090
7091	7092	7093	7094	7097	7098	7100	7101	7102	7103	7104
7105	7106	7107	7111	7112	7113	7114	7115	7122	7123	7125
7126	7130	7135	7136	7155	7158	7159	7163	7176	7188	7191
7193	7200	7218	7219	7222	8467					

16. Most of the amendments are self explanatory, however the following notes are provided for clarification.

ARTERIAL AND VENOUS PATCHES

17. Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

18. Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct items would be 4807, 4719 and 4785. If vein is harvested for the patch through a separate incision, Item 4720 would also apply, in accordance with the multiple operation rule.

19. If a patch graft is involved in conjunction with an operative procedure included in Items

4697, 4698, 4700, 4701, 4703, 4704, 4706, 4707, 4708, 4710, 4711, 4712, 4713, 4714, 4716, 4724, 4725, 4728, 4735 or 4763, the patch graft would attract benefits under Item 4717 or 4718 in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item 4720 would also apply.

AESTHETIC AREA

20. For the purposes of items 8455 and 8456 one aesthetic area is any one of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

FOREIGN IMPLANT (ITEM 8478)

21. For Medicare Benefits to be payable for this item the intention of the implantation must be either to reconstruct facial or body contours which have been damaged by trauma or disease or to correct a deformity which has been pathologically caused.

LIPOSUCTION

22. Medicare benefit is generally only attracted for liposuction under item 8550, that is, for the treatment of post-traumatic pseudolipoma. However, where liposuction is used in the treatment of other medical conditions, such as pathological lipodystrophy, payment of Medicare benefit will be considered on an individual basis. Clinical details of such cases, including, where possible, colour photographs, should be submitted to the local Medicare office for forwarding to the Medicare Benefits Advisory Committee for consideration. The information should be forwarded in a sealed envelope marked "Medical - In Confidence".

LOCAL SKIN FLAP - AMENDED DEFINITION

23. A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This latter procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

24. By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

25. A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Item 8480, 8481 or 8483 once only.

26. Items, where benefit for local skin flap repair (if indicated as above) is payable, include:

3041	3276	7815	8467	8526
3219/3220	3295	7817	8471	8588
3221/3222	3301	7821	8473	
3233/3237	3314	7823	8475	
3247/3253	3320	8298	8522	
3261/3265	3477	8462	8524	
3271	6044	8466	8525	

Note: This list is not all-inclusive and there are circumstances where other services might involve flap repair.

27. Items where a local flap repair should not be payable in addition are:

3046-3101	3306-3311	8542	8612
3104	3597	8551	8622-8648
3173-3217	8528	8594-8600	
3223-3226	8530	8608	

SPECIAL ARRANGEMENTS - TRANSITION PERIOD

28. Where the description, item number or Schedule fee for an item has been amended the following rules will apply:-

    (a) If the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 May 1991 and continues beyond that date, the old item number, fee and benefit levels will apply.

    (b) In any other case the date the service is rendered will determine which item and fee is applicable.

29. As announced in the May 1990 reprint it is proposed to introduce a five digit numbering system for Medicare benefit items. The date of effect for this is now expected to be 1 November 1991.

SCHEDULE INTERPRETATIONS

30. The day-to-day administration and payment of benefits under the Medicare arrangements is the responsibility of the Health Insurance Commission. Inquiries concerning matters of interpretation of Schedule items should be directed to the Commission and not to the Department of Community Services and Health. The following telephone numbers have been reserved exclusively for inquiries relating to the Schedule:

NSW - 02 5612212	TAS - 002 347999
VIC - 03 6079273	ACT - 06 2936360
QLD - 07 3607215	NT - use SA inquiry number
SA - 08 2018629	
WA - 09 3220044	

31. It is also important that the Health Insurance Commission be notified promptly of changes to mailing addresses to ensure receipt of the Medicare Benefits Schedule book and its supplements. Failure to notify changes could result in non-receipt of the book. Addresses of the Commission are listed on pages 8 and 9 of the 1 May 1990 reprint of the MBS Book.

OPERATIONS	GENERAL SURGICAL
	PART 10 - OPERATIONS
	DIVISON 1 - GENERAL SURGICAL
	(NB: Items 3004 - 4617 and 4838 - 4877 in this Division unchanged)
* 4618	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (AU 6 - 407/513) **Fee:** $64.00 **Benefit:** 75% $48.00: 85%/$26 $54.40
* 4619	TELANGIECTASES OR STARBURST VESSELS, diathermy or sclerosant injection of, including associated consultation **Fee:** $73.00 **Benefit:** 75% $54.75: 85%/$26 $62.05
* 4620	**VASCULAR SURGERY** **VARICOSE VEINS** VARICOSE VEINS, multiple simultaneous injections by continuous compression techniques including associated consultation - ONE OR BOTH LEGS - not associated with any other varicose veins operation on the same leg (excluding after-care) **Fee:** $93.00 **Benefit:** 75% $69.75: 85%/$26 $79.05
* 4621	VARICOSE VEINS, multiple ligations, with or without local stripping or excision, including sub-fascial ligation of one or more deep perforating veins through separate incisions - ONE LEG - not associated with item 4624, 4625 or 4632 on the same leg (AU 7 - 408/514) **Fee:** $178.00 **Benefit:** 75% $133.50: 85%/$26 $152.00
* 4623	VARICOSE VEINS, complete dissection at SAPHENO-FEMORAL JUNCTION, with or without ligation of long saphenous vein, with or without ligation of the major tributaries at sapheno-femoral junction - ONE LEG (AU 6 - 407/513) **Fee:** $215.00 **Benefit:** 75% $161.25: 85%/$26 $189.00
* ‡ + 4624	VARICOSE VEINS, high ligation and complete or partial stripping or excision of long or short saphenous vein or its major tributaries, with multiple ligations, local stripping or excision of minor veins, with or without sclerotherapy of minor veins - one leg (AU 10 - 450/521) **Fee:** $325.00 **Benefit:** 75% $243.75: 85%/$26 $299.00
* ‡ + 4625	VARICOSE VEINS, high ligation and stripping or excision of both long and short saphenous veins or their major tributaries, with multiple ligations, local stripping or excision of minor veins, with or without sclerotherapy of minor veins - one leg (AU 12 - 454/523) **Fee:** $490.00 **Benefit:** 75% $367.50: 85%/$26 $464.00
† 4626	LONG SAPHENOUS VEIN, complete dissection and ligation of, at the sapheno-femoral junction, for migrating thrombosis of long saphenous vein (AU 11 - 453/522) **Fee:** $295.00 **Benefit:** 75% $221.25: 85%/$26 $269.00

* ‡ 4627	VARICOSE VEINS, complete dissection at sapheno-popliteal junction, with or without ligation of the short saphenous vein, with or without ligation of the major tributaries at the sapheno-popliteal junction - one leg (AU 6 - 407/513) **Fee:** $215.00 **Benefit:** 75% $161.25: 85%/$26 $189.00
* 4628	VARICOSE VEINS, sub-fascial ligation of single deep perforating vein not associated with any other varicose vein operation on the same leg - ONE LEG (AU 6 - 407/513) **Fee:** $134.00 **Benefit:** 75% $100.50: 85%/$26 $113.90
* ‡ + 4629	VARICOSE VEINS, sub-fascial ligation of multiple deep perforating vein - one leg (Cockett's operation, Linton's operation or similar procedure (AU 7 - 408/514) **Fee:** $330.00 **Benefit:** 75% $247.50: 85%/$26 $304.00
† 4631	GROIN OR POPLITEAL FOSSA, reoperation in, for recurrent sapheno-popliteal incompetence - one leg (AU 12 - 454/523) **Fee:** $400.00 **Benefit:** 75% $300.00: 85%/$26 $374.00
* ‡ + 4632	GROIN OR POPLITEAL FOSSA, reoperation in, for recurrent sapheno-femoral incompetence or recurrent sapheno-popliteal incompetence with one or more of the following - multiple ligations, local stripping or excision of minor veins or sclerotherapy of minor veins - one leg (AU 13 - 457/524) **Fee:** $525.00 **Benefit:** 75% $393.75: 85%/$26 $499.00
† 4634	**BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE** ARTERY OF NECK, bypass using vein or synthetic material (AU 19 - 463/531) **Fee:** $955.00 **Benefit:** 75% $716.25: 85%/$26 $929.00
† 4636	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (AU 18 - 462/529) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00
† 4638	INTERNAL CAROTID ARTERY, re-operation for recurrent stenosis with by-pass by graft of vein or synthetic material (AU 19 - 463/531) **Fee:** $1,130.00 **Benefit:** 75% $847.50: 85%/$26 $1,104.00
* ‡ @ + 4639	AORTO-ILIAC OR AORTO-FEMORAL GRAFTING, straight or bifurcated (AU 21 - 465/535) **Fee:** $930.00 **Benefit:** 75% $697.50: 85%/$26 $904.00
† 4640	ILIO-FEMORAL BYPASS GRAFTING (AU 18 - 462/529) **Fee:** $835.00 **Benefit:** 75% $626.25: 85%/$26 $809.00
* ‡ @ + 4642	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to one or both FEMORAL ARTERIES (AU 19 - 463/531) **Fee:** $835.00 **Benefit:** 75% $626.25: 85%/$26 $809.00

LEGEND: † New Service ‡ Description Amended + Fees Amended @ AU Units Amended * Item no. Changed

Item	Description
† 4643	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (AU 18 - 462/529) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00
† 4644	RENAL ARTERY, bypass grafting to (AU 22 - 466/537) **Fee:** $1,255.00 **Benefit:** 75% $941.25: 85%/$26 $1,229.00
† 4645	RENAL ARTERIES (both), bypass grafting to (AU 26 - 470/541) **Fee:** $1,425.00 **Benefit:** 75% $1,068.75: 85%/$26 $1,399.00
† 4646	SPLENO-RENAL ARTERIAL BYPASS GRAFTING (AU 21 - 465/535) **Fee:** $1,255.00 **Benefit:** 75% $941.25: 85%/$26 $1,229.00
† 4647	MESENTERIC VESSEL (single), bypass grafting to (AU 18 - 462/529) **Fee:** $1,080.00 **Benefit:** 75% $810.00: 85%/$26 $1,054.00
† 4648	MESENTERIC VESSELS (multiple), bypass grafting to (AU 21 - 465/535) **Fee:** $1,255.00 **Benefit:** 75% $941.25: 85%/$26 $1,229.00
† 4650	INFERIOR MESENTERIC ARTERY, operation on, when performed in association with another intra-abdominal vascular operation (AU 17 - 461/528) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
† 4652	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (AU 19 - 463/531) **Fee:** $860.00 **Benefit:** 75% $645.00: 85%/$26 $834.00
† 4653	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (AU 20 - 464/533) **Fee:** $985.00 **Benefit:** 75% $738.75: 85%/$26 $959.00
† 4654	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (AU 21 - 465/535) **Fee:** $1,125.00 **Benefit:** 75% $843.75: 85%/$26 $1,099.00
† 4656	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (AU 22 - 466/537) **Fee:** $1,220.00 **Benefit:** 75% $915.00: 85%/$26 $1,194.00
† 4657	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (AU 18 - 462/529) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00

Item	Description
† 4659	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at one or both anastomoses (AU 20 - 464/533) **Fee:** $985.00 **Benefit:** 75% $738.75: 85%/$26 $959.00
† 4660	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than one artery - each additional artery revascularised beyond a femoral bypass (AU 16 - 460/527) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
† 4661	VEIN, harvesting of from leg or arm for bypass or replacement graft when not performed through same incision as operation - each vein (AU 9 - 443/518) **Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00
† 4663	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not covered by any other item in this Part (AU 18 - 462/529) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00
† 4666	ARTERIAL OR VENOUS ANASTOMOSIS, not covered by any other item in this Part, as an independent procedure (AU 15 - 459/526) **Fee:** $525.00 **Benefit:** 75% $393.75: 85%/$26 $499.00
† 4667	ARTERIAL OR VENOUS ANASTOMOSIS not covered by any other item in this Part, when performed in combination with another vascular operation (including graft to graft anastomosis) (AU 15 - 459/526) **Fee:** $182.00 **Benefit:** 75% $136.50: 85%/$26 $156.00
† 4668	**BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS** ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (AU 20 - 464/533) **Fee:** $955.00 **Benefit:** 75% $716.25: 85%/$26 $929.00
† 4669	THORACIC ANEURYSM, replacement by graft (AU 35 - 493/564) **Fee:** $1,340.00 **Benefit:** 75% $1,005.00: 85%/$26 $1,314.00
* ‡ + 4670	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (AU 40 - 479/550) **Fee:** $1,620.00 **Benefit:** 75% $1,215.00: 85%/$26 $1,594.00
† 4671	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (AU 35 - 493/564) **Fee:** $1,405.00 **Benefit:** 75% $1,053.75: 85%/$26 $1,379.00
† 4672	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (AU 26 - 470/541) **Fee:** $985.00 **Benefit:** 75% $738.75: 85%/$26 $959.00

† 4673	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) (AU 29 - 473/544) **Fee:** $1,125.00 **Benefit:** 75% $843.75: 85%/$26 $1,099.00
† 4674	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (AU 29 - 473/544) **Fee:** $1,125.00 **Benefit:** 75% $843.75: 85%/$26 $1,099.00
† 4675	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (AU 18 - 462/529) **Fee:** $805.00 **Benefit:** 75% $603.75: 85%/$26 $779.00
† 4676	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (AU 20 - 464/533) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
† 4677	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (AU 18 - 462/529) **Fee:** $920.00 **Benefit:** 75% $690.00: 85%/$26 $894.00
† 4678	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (AU 16 - 460/527) **Fee:** $690.00 **Benefit:** 75% $517.50: 85%/$26 $664.00
† 4679	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (AU 25 - 469/540) **Fee:** $1,740.00 **Benefit:** 75% $1,305.00: 85%/$26 $1,714.00
† 4680	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (AU 19 - 463/531) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
† 4681	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (AU 18 - 462/529) **Fee:** $985.00 **Benefit:** 75% $738.75: 85%/$26 $959.00
† 4682	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (AU 38 - 477/548) **Fee:** $1,695.00 **Benefit:** 75% $1,271.25: 85%/$26 $1,669.00
† 4683	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (AU 40 - 479/550) **Fee:** $2,105.00 **Benefit:** 75% $1,578.75: 85%/$26 $2,079.00
† 4684	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (AU 38 - 477/548) **Fee:** $2,000.00 **Benefit:** 75% $1,500.00: 85%/$26 $1,974.00

† 4685	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (AU 28 - 472/543) **Fee: $1,480.00** **Benefit: 75% $1,110.00: 85%/$26 $1,454.00**
† 4686	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (AU 30 - 474/545) **Fee: $1,650.00** **Benefit: 75% $1,237.50: 85%/$26 $1,624.00**
† 4687	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both femoral arteries (AU 30 - 474/545) **Fee: $1,650.00** **Benefit: 75% $1,237.50: 85%/$26 $1,624.00**
† 4689	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (AU 22 - 466/537) **Fee: $1,400.00** **Benefit: 75% $1,050.00: 85%/$26 $1,374.00**
† 4691	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (AU 22 - 466/537) **Fee: $1,400.00** **Benefit: 75% $1,050.00: 85%/$26 $1,374.00**
† 4692	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (AU 18 - 462/529) **Fee: $1,090.00** **Benefit: 75% $817.50: 85%/$26 $1,064.00**
† 4694	ANEURYSM OF MAJOR ARTERY, replacement by graft, not covered by any other item in this Part (AU 21 - 465/535) **Fee: $850.00** **Benefit: 75% $637.50: 85%/$26 $824.00**
† 4697	**ENDARTERECTOMY AND ARTERIAL PATCH** ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of one or more arteries is undertaken through one arteriotomy incision) (AU 17 - 461/528) **Fee: $755.00** **Benefit: 75% $566.25: 85%/$26 $729.00**
† 4698	INTERNAL CAROTID ARTERY, re-operation for recurrent stenosis with endarterectomy and closure by suture (AU 19 - 463/531) **Fee: $955.00** **Benefit: 75% $716.25: 85%/$26 $929.00**
† 4700	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (AU 18 - 462/529) **Fee: $845.00** **Benefit: 75% $633.75: 85%/$26 $819.00**
† 4701	AORTIC ENDARTERECTOMY, including closure by suture, not associated with another procedure on the aorta (AU 18 - 462/529) **Fee: $875.00** **Benefit: 75% $656.25: 85%/$26 $849.00**

† 4703	AORTO-ILIAC ENDARTERECTOMY (one or both iliac arteries), including closure by suture not associated with Item 4704 (AU 19 - 463/531) **Fee:** $945.00 **Benefit:** 75% $708.75: 85%/$26 $919.00
† 4704	AORTO-FEMORAL ENDARTERECTOMY (one or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not in association with Item 4703 (AU 20 - 464/533) **Fee:** $1,015.00 **Benefit:** 75% $761.25: 85%/$26 $989.00
† 4706	ILIAC ENDARTERECTOMY, including closure by suture, not associated with another procedure on the iliac artery (AU 17 - 461/528) **Fee:** $845.00 **Benefit:** 75% $633.75: 85%/$26 $819.00
† 4707	ILIO-FEMORAL ENDARTERECTOMY (one side), including closure by suture (AU 17 - 461/528) **Fee:** $915.00 **Benefit:** 75% $686.25: 85%/$26 $889.00
† 4708	RENAL ARTERY, endarterectomy of (AU 19 - 463/531) **Fee:** $1,080.00 **Benefit:** 75% $810.00: 85%/$26 $1,054.00
† 4710	RENAL ARTERIES (both), endarterectomy of (AU 21 - 465/535) **Fee:** $1,255.00 **Benefit:** 75% $941.25: 85%/$26 $1,229.00
† 4711	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (AU 19 - 463/531) **Fee:** $1,080.00 **Benefit:** 75% $810.00: 85%/$26 $1,054.00
† 4712	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (AU 20 - 464/533) **Fee:** $1,255.00 **Benefit:** 75% $941.25: 85%/$26 $1,229.00
† 4713	INFERIOR MESENTERIC ARTERY, endarterectomy of, not associated with any other item in this Part (AU 19 - 463/531) **Fee:** $895.00 **Benefit:** 75% $671.25: 85%/$26 $869.00
† 4714	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (AU 12 - 454/523) **Fee:** $645.00 **Benefit:** 75% $483.75: 85%/$26 $619.00
† 4716	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (AU 17 - 461/528) **Fee:** $920.00 **Benefit:** 75% $690.00: 85%/$26 $894.00
† 4717	ARTERY OR VEIN, patch grafting to by vein or synthetic material in association with another arterial or venous operation where patch is less than 3cm long (AU 13 - 457/524) **Fee:** $182.00 **Benefit:** 75% $136.50: 85%/$26 $156.00

Item	Description
† 4718	ARTERY OR VEIN, patch grafting to by vein or synthetic material in association with another arterial or venous operation where patch is 3cm long or greater (AU 14 - 458/525) **Fee:** $370.00 **Benefit:** 75% $277.50: 85%/$26 $344.00
* ‡ @ + 4719	ARTERY OR VEIN BYPASS GRAFT, patch grafting to using vein or synthetic material, not associated with any other vascular operation (AU 14 - 458/525) **Fee:** $470.00 **Benefit:** 75% $352.50: 85%/$26 $444.00
† 4720	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (AU 9 - 443/518) **Fee:** $182.00 **Benefit:** 75% $136.50: 85%/$26 $156.00
† 4722	ENDARTERECTOMY, in association with an arterial bypass operation to prepare the site for anastomosis - each site (AU 16 - 460/527) **Fee:** $94.00 **Benefit:** 75% $70.50: 85%/$26 $79.90
† 4723	**EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA** EMBOLUS, removal of, from artery of neck (AU 15 - 459/526) **Fee:** $785.00 **Benefit:** 75% $588.75: 85%/$26 $759.00
* ‡ @ + 4724	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (AU 16 - 460/527) **Fee:** $750.00 **Benefit:** 75% $562.50: 85%/$26 $724.00
† 4725	EMBOLECTOMY OR THROMBECTOMY, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (AU 11 - 453/522) **Fee:** $540.00 **Benefit:** 75% $405.00: 85%/$26 $514.00
† 4726	INFERIOR VENA CAVA OR ILIAC VEIN, thrombectomy of (AU 12 - 454/523) **Fee:** $665.00 **Benefit:** 75% $498.75: 85%/$26 $639.00
* ‡ @ + 4727	THROMBUS, removal of, from femoral or other similar large vein (AU 10 - 450/521) **Fee:** $620.00 **Benefit:** 75% $465.00: 85%/$26 $594.00
† 4728	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (AU 12 - 454/523) **Fee:** $570.00 **Benefit:** 75% $427.50: 85%/$26 $544.00
† 4729	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (AU 13 - 457/524) **Fee:** $665.00 **Benefit:** 75% $498.75: 85%/$26 $639.00
† 4730	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (AU 15 - 459/526) **Fee:** $760.00 **Benefit:** 75% $570.00: 85%/$26 $734.00

† 4731	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (AU 13 - 457/524) **Fee:** $725.00 **Benefit:** 75% $543.75: 85%/$26 $699.00
† 4732	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (AU 14 - 458/525) **Fee:** $850.00 **Benefit:** 75% $637.50: 85%/$26 $824.00
† 4734	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (AU 16 - 460/527) **Fee:** $975.00 **Benefit:** 75% $731.25: 85%/$26 $949.00
† 4735	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (AU 16 - 460/527) **Fee:** $885.00 **Benefit:** 75% $663.75: 85%/$26 $859.00
† 4736	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (AU 17 - 461/528) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
† 4737	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (AU 18 - 462/529) **Fee:** $1,235.00 **Benefit:** 75% $926.25: 85%/$26 $1,209.00
† 4739	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (AU 12 - 454/523) **Fee:** $610.00 **Benefit:** 75% $457.50: 85%/$26 $584.00
† 4740	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (AU 14 - 458/525) **Fee:** $425.00 **Benefit:** 75% $318.75: 85%/$26 $399.00
† 4741	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (AU 12 - 454/523) **Fee:** $425.00 **Benefit:** 75% $318.75: 85%/$26 $399.00
† 4742	**LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS** MAJOR ARTERY OF NECK, elective ligation or exploration of, not associated with any other vascular procedure (AU 11 - 453/522) **Fee:** $470.00 **Benefit:** 75% $352.50: 85%/$26 $444.00
* ‡ @ + 4743	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not associated with any other vascular procedure (AU 13 - 457/524) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00

* ‡ @ + 4746	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not associated with any other vascular procedure (AU 9 - 443/518) **Fee:** $194.00 **Benefit:** 75% $145.50: 85%/$26 $168.00
† 4747	TEMPORAL ARTERY, biopsy of (AU 7 - 408/514) **Fee:** $225.00 **Benefit:** 75% $168.75: 85%/$26 $199.00
† 4748	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (AU 14 - 458/525) **Fee:** $570.00 **Benefit:** 75% $427.50: 85%/$26 $544.00
† 4750	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (AU 17 - 461/528) **Fee:** $645.00 **Benefit:** 75% $483.75: 85%/$26 $619.00
† 4751	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (AU 19 - 463/531) **Fee:** $920.00 **Benefit:** 75% $690.00: 85%/$26 $894.00
† 4752	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (AU 18 - 462/529) **Fee:** $735.00 **Benefit:** 75% $551.25: 85%/$26 $709.00
† 4753	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (AU 18 - 462/529) **Fee:** $805.00 **Benefit:** 75% $603.75: 85%/$26 $779.00
† 4757	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (AU 22 - 466/537) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
† 4758	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (AU 10 - 450/521) **Fee:** $330.00 **Benefit:** 75% $247.50: 85%/$26 $304.00
* @ + 4759	SCALENOTOMY (AU 10 - 450/521) **Fee:** $370.00 **Benefit:** 75% $277.50: 85%/$26 $344.00
* ‡ + 4760	FIRST RIB, resection of portion of (AU 13 - 457/524) **Fee:** $595.00 **Benefit:** 75% $446.25: 85%/$26 $569.00
* ‡ @ + 4761	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not covered by any other item in this Part (AU 13 - 457/524) **Fee:** $595.00 **Benefit:** 75% $446.25: 85%/$26 $569.00
† 4763	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (AU 19 - 463/531) **Fee:** $735.00 **Benefit:** 75% $551.25: 85%/$26 $709.00

* ‡ @ + 4765	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (AU 13 - 457/524) **Fee:** $535.00 **Benefit:** 75% $401.25: 85%/$26 $509.00
† 4767	CAROTID BODY TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is less that 4cm in maximum diameter (AU 19 - 463/531) **Fee:** $955.00 **Benefit:** 75% $716.25: 85%/$26 $929.00
† 4768	CAROTID BODY TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (AU 19 - 463/531) **Fee:** $1,305.00 **Benefit:** 75% $978.75: 85%/$26 $1,279.00
† 4769	RECURRENT CAROTID BODY TUMOUR, resection of, with or without repair or replacement of portion of common or internal carotid arteries (AU 19 - 463/531) **Fee:** $1,555.00 **Benefit:** 75% $1,166.25: 85%/$26 $1,529.00
† 4770	NECK, excision of infected bypass graft, including closure of vessel or vessels (AU 15 - 459/526) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00
† 4771	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (AU 24 - 468/539) **Fee:** $1,480.00 **Benefit:** 75% $1,110.00: 85%/$26 $1,454.00
† 4772	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (AU 26 - 470/541) **Fee:** $1,900.00 **Benefit:** 75% $1,425.00: 85%/$26 $1,874.00
† 4773	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (AU 26 - 470/541) **Fee:** $1,900.00 **Benefit:** 75% $1,425.00: 85%/$26 $1,874.00
* ‡ @ + 4774	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (AU 20 - 464/533) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
† 4775	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (AU 15 - 459/526) **Fee:** $860.00 **Benefit:** 75% $645.00: 85%/$26 $834.00
† 4776	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (AU 15 - 459/526) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00

* +	**OPERATIONS FOR VASCULAR DISEASE**
4777	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (AU 9 - 443/518) **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00
† 4779	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in association with another venous or arterial operation (AU 14 - 458/525) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
* + 4780	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (AU 5 - 406/510) **Fee:** $140.00 **Benefit:** 75% $105.00: 85%/$26 $119.00
† 4781	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in association with another venous or arterial operation (AU 14 - 458/525) **Fee:** $650.00 **Benefit:** 75% $487.50: 85%/$26 $624.00
† 4782	ARTERIOVENOUS ACCESS DEVICE, insertion of (AU 14 - 458/525) **Fee:** $715.00 **Benefit:** 75% $536.25: 85%/$26 $689.00
† 4783	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (AU 11 - 453/522) **Fee:** $510.00 **Benefit:** 75% $382.50: 85%/$26 $484.00
† 4785	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (AU 14 - 458/525) **Fee:** $855.00 **Benefit:** 75% $641.25: 85%/$26 $829.00
* ‡ @ + 4786	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of for infusion chemotherapy, by open operation (excluding aftercare) (AU 11 - 453/522) **Fee:** $350.00 **Benefit:** 75% $262.50: 85%/$26 $324.00
* + 4787	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not covered by Item 4786 (excluding after-care) (AU 10 - 450/521) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
* ‡ @ + 4788	CENTRAL VEIN CATHETERISATION by open exposure, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (AU 11 - 453/522) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
† 4790	HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of (AU 10 - 450/521) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
* ‡ @ + 4793	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (AU 18 - 462/529) **Fee:** $825.00 **Benefit:** 75% $618.75: 85%/$26 $799.00

Item	Description
†	**ENDOVASCULAR INTERVENTION PROCEDURES**
4795	INFERIOR VENA CAVAL FILTER, insertion of, by percutaneous method using interventional imaging techniques (AU 11 - 453/522) **Fee:** $510.00 **Benefit:** 75% $382.50: 85%/$26 $484.00
† 4796	INFERIOR VENA CAVAL FILTER, insertion of, by open operation (AU 12 - 454/523) **Fee:** $540.00 **Benefit:** 75% $405.00: 85%/$26 $514.00
* ‡ @ +	**COMPLEX VENOUS OPERATIONS**
4797	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (AU 13 - 457/524) **Fee:** $540.00 **Benefit:** 75% $405.00: 85%/$26 $514.00
† 4799	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (AU 24 - 468/539) **Fee:** $1,190.00 **Benefit:** 75% $892.50: 85%/$26 $1,164.00
* ‡ @ + 4803	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (AU 14 - 458/525) **Fee:** $645.00 **Benefit:** 75% $483.75: 85%/$26 $619.00
† 4804	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (AU 14 - 458/525) **Fee:** $645.00 **Benefit:** 75% $483.75: 85%/$26 $619.00
† 4805	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not associated with items 4803 or 4804 (AU 13 - 457/524) **Fee:** $780.00 **Benefit:** 75% $585.00: 85%/$26 $754.00
† 4807	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (AU 15 - 459/526) **Fee:** $645.00 **Benefit:** 75% $483.75: 85%/$26 $619.00
† 4809	VENOUS VALVE, plication or repair to restore valve competency (AU 25 - 469/540) **Fee:** $710.00 **Benefit:** 75% $532.50: 85%/$26 $684.00
† 4810	VEIN TRANSPLANT to restore valvular function (AU 15 - 459/526) **Fee:** $965.00 **Benefit:** 75% $723.75: 85%/$26 $939.00
† 4811	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - one stent (AU 10 - 450/521) **Fee:** $330.00 **Benefit:** 75% $247.50: 85%/$26 $304.00

† 4815	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than one stent (AU 11 - 453/522) **Fee:** $400.00 **Benefit:** 75% $300.00: 85%/$26 $374.00
† 4816	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (one stent) (AU 11 - 453/522) **Fee:** $470.00 **Benefit:** 75% $352.50: 85%/$26 $444.00
† 4818	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than one stent) (AU 12 - 454/523) **Fee:** $610.00 **Benefit:** 75% $457.50: 85%/$26 $584.00
* ‡ @ + 4819	PORTAL HYPERTENSION, vascular decompression operation for (including spleno-renal, porto-caval and mesenterico-caval anastomosis) (AU 24 - 468/539) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
† 4820	**SYMPATHECTOMY** LUMBAR SYMPATHECTOMY (AU 11 - 453/522) **Fee:** $470.00 **Benefit:** 75% $352.50: 85%/$26 $444.00
† 4821	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (AU 16 - 460/527) **Fee:** $610.00 **Benefit:** 75% $457.50: 85%/$26 $584.00
† 4826	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (AU 13 - 457/524) **Fee:** $765.00 **Benefit:** 75% $573.75: 85%/$26 $739.00
† 4827	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (AU 11 - 453/522) **Fee:** $595.00 **Benefit:** 75% $446.25: 85%/$26 $569.00
† 4828	**DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE** ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (AU 8 - 409/517) **Fee:** $245.00 **Benefit:** 75% $183.75: 85%/$26 $219.00
† 4831	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (AU 9 - 443/518) **Fee:** $156.00 **Benefit:** 75% $117.00: 85%/$26 $132.60

†	**MISCELLANEOUS VASCULAR PROCEDURES**
4834	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, one or more of, performed during the course of an operative prodedure on an artery or vein on one leg (AU 8 - 409/517) **Fee:** $114.00 **Benefit:** 75% $85.50: 85%/$26 $96.90
* 4835	TRANSLUMINAL BALLOON ANGIOPLASTY OF CORONARY ARTERY AND DILATATION OF VESSEL, using interventional imaging techniques (AU 12 - 454/523) **Fee:** $345.00 **Benefit:** 75% $258.75: 85%/$26 $319.00
* 4836	TRANSLUMINAL BALLOON ANGIOPLASTY OF PERIPHERAL VESSEL AND DILATATION OF VESSEL, using interventional imaging techniques (AU 12 - 454/523) **Fee:** $345.00 **Benefit:** 75% $258.75: 85%/$26 $319.00
*	**OPERATIONS FOR ACUTE OSTEOMYELITIS**
4837	OPERATION ON PHALANX (AU 7 - 408/514) **Fee:** $82.00 **Benefit:** 75% $61.50: 85%/$26 $69.70

PART 10 - OPERATIONS

DIVISION 3 - EAR, NOSE AND THROAT

Item	Description
‡ 5108	CEREBELLO - PONTINE ANGLE TUMOUR, removal of by two surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach - transmastoid, translabyrinthine or retromastoid procedure (including after-care) (AU 39 - 478/549) **Fee:** $1,620.00 **Benefit:** 75% $1,215.00: 85%/$26 $1,594.00
‡ 5112	CEREBELLO - PONTINE ANGLE TUMOUR, removal of by two surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including after-care) **Fee:** $1,620.00 **Benefit:** 75% $1,215.00: 85%/$26 $1,594.00

DIVISION 7 - THORACIC

Item	Description
* 7015	INTRA-AORTIC BALLOON FOR COUNTERPULSATION, operation for insertion by arteriotomy, or removal and arterioplasty (excluding repair by patch graft) (AU 14 - 458/525) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00

PART 10 - OPERATIONS

DIVISION 8 - NEURO-SURGICAL

* ‡ 7070	LUMBAR PUNCTURE, or spinal or epidural injection not covered by Item 748 (AU 5 - 406/510) **Fee:** $50.00 **Benefit:** 75% $37.50: 85%/$26 $42.50
* 7071	CISTERNAL PUNCTURE **Fee:** $57.00 **Benefit:** 75% $42.75: 85%/$26 $48.45
* + 7072	**DIAGNOSTIC PROCEDURES** VENTRICULAR PUNCTURE (not including burr-hole) **Fee:** $106.00 **Benefit:** 75% $79.50: 85%/$26 $90.10
* + 7073	SUBDURAL HAEMORRHAGE, tap for, each tap (AU 6 - 407/513) **Fee:** $39.50 **Benefit:** 75% $29.65: 85%/$26 $33.60
* + 7074	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not included in any other Items (AU 11 - 453/522) **Fee:** $158.00 **Benefit:** 75% $118.50: 85%/$26 $134.30
* ‡ 7075	VENTRICULAR RESERVOIR or intracranial pressure monitoring device, insertion of - including burr-hole (excluding after-care) (AU 12 - 454/523) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
† 7076	CEREBROSPINAL FLUID reservoir, insertion of (AU 10 - 450/521) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
* ‡ + 7077	**PROCEDURES FOR PAIN RELIEF** INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (AU 8 - 409/517) **Fee:** $158.00 **Benefit:** 75% $118.50: 85%/$26 $134.30
* + 7078	INTRATHECAL INJECTION of alcohol or phenol **Fee:** $158.00 **Benefit:** 75% $118.50: 85%/$26 $134.30
* ‡ 7080	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (AU 16 - 460/527) **Fee:** $790.00 **Benefit:** 75% $592.50: 85%/$26 $764.00
* ‡ 7082	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (AU 8 - 409/517) **Fee:** $295.00 **Benefit:** 75% $221.25: 85%/$26 $269.00

Item	Description
* ‡ 7083	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (AU 25 - 469/540) **Fee:** $1,025.00 **Benefit:** 75% $768.75: 85%/$26 $999.00
* + 7084	PERCUTANEOUS NEUROTOMY of posterior divisions of spinal nerves by any method on one or more occasions within a thirty day period, including any spinal, epidural or regional nerve block given at the time of such neurotomy (AU 6 - 407/513) **Fee:** $66.00 **Benefit:** 75% $49.50: 85%/$26 $56.10
† 7086	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (AU 7 - 408/514) **Fee:** $198.00 **Benefit:** 75% $148.50: 85%/$26 $172.00
* 7087	PERCUTANEOUS CORDOTOMY (AU 9 - 443/518) **Fee:** $420.00 **Benefit:** 75% $315.00: 85%/$26 $394.00
† 7088	CORDOTMY OR MYELOTOMY, laminectomy for, or operation for dorsal root entry zone (Drez) lesion (AU 13 - 457/524) **Fee:** $1,075.00 **Benefit:** 75% $806.25: 85%/$26 $1,049.00
* ‡ + 7090	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER FOR PAIN, insertion of (AU 8 - 409/517) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
* ‡ + 7091	PERCUTANEOUS EPIDURAL IMPLANT FOR PAIN, insertion of (one or two stages), not involving laminectomy (AU 8 - 409/517) **Fee:** $435.00 **Benefit:** 75% $326.25: 85%/$26 $409.00
* ‡ + 7092	EPIDURAL STIMULATOR or INTRATHECAL INFUSION DEVICE, revision of (AU 7 - 408/514) **Fee:** $106.00 **Benefit:** 75% $79.50: 85%/$26 $90.10
* ‡ + 7093	PERCUTANEOUS EPIDURAL IMPLANT FOR PAIN, removal of (AU 7 - 408/514) **Fee:** $106.00 **Benefit:** 75% $79.50: 85%/$26 $90.10
* ‡ + 7094	EPIDURAL IMPLANT FOR PAIN, laminectomy and insertion of, including implantation of pulse generator (one or two stages) (AU 18 - 462/529) **Fee:** $715.00 **Benefit:** 75% $536.25: 85%/$26 $689.00
* ‡ 7095	**PERIPHERAL NERVES** CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (AU 9 - 443/518) **Fee:** $235.00 **Benefit:** 75% $176.25: 85%/$26 $209.00
* ‡ 7096	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (AU 10 - 450/521) **Fee:** $310.00 **Benefit:** 75% $232.50: 85%/$26 $284.00

* ‡ + 7097	NERVE TRUNK, primary repair of, using microsurgical techniques (AU 11 - 453/522) **Fee:** $450.00 **Benefit:** 75% $337.50: 85%/$26 $424.00
* ‡ + 7098	NERVE TRUNK, secondary repair of, using microsurgical techniques (AU 12 - 454/523) **Fee:** $475.00 **Benefit:** 75% $356.25: 85%/$26 $449.00
* ‡ + 7100	NERVE TRUNK, internal (interfasicular), neurolysis of, using microsurgical techniques (AU 11 - 453/522) **Fee:** $265.00 **Benefit:** 75% $198.75: 85%/$26 $239.00
* ‡ + 7101	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (AU 16 - 460/527) **Fee:** $685.00 **Benefit:** 75% $513.75: 85%/$26 $659.00
* ‡ + 7102	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (AU 12 - 454/523) **Fee:** $425.00 **Benefit:** 75% $318.75: 85%/$26 $399.00
* + 7103	NERVE, transposition of (AU 8 - 409/517) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
* + 7104	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve (AU 8 - 409/517) **Fee:** $184.00 **Benefit:** 75% $138.00: 85%/$26 $158.00
* + 7105	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve (AU 10 - 450/521) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
* ‡ + 7106	NEUROLYSIS by open operation without transposition, not associated with Item 7100 (AU 7 - 408/514) **Fee:** $184.00 **Benefit:** 75% $138.00: 85%/$26 $158.00
* ‡ + 7107	BRACHIAL PLEXUS, exploration of not covered by any other item in this Part (AU 11 - 453/522) **Fee:** $265.00 **Benefit:** 75% $198.75: 85%/$26 $239.00
† 7108	**CRANIAL NERVES** VESTIBULAR NERVE, section of, via posterior fossa (AU 24 - 468/539) **Fee:** $845.00 **Benefit:** 75% $633.75: 85%/$26 $819.00
† 7109	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (AU 28 - 472/543) **Fee:** $635.00 **Benefit:** 75% $476.25: 85%/$26 $609.00

*	**CRANIO-CEREBRAL INJURIES**
7110	Intracranial haemorrhage, burr-hole craniotomy for - including burr holes (AU 11 - 453/522) Fee: $315.00 Benefit: 75% $236.25: 85%/$26 $289.00
* + 7111	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (AU 18 - 462/529) Fee: $795.00 Benefit: 75% $596.25: 85%/$26 $769.00
* ‡ + 7112	FRACTURED SKULL, depressed or comminuted, operation for (AU 12 - 454/523) Fee: $530.00 Benefit: 75% $397.50: 85%/$26 $504.00
* + 7113	FRACTURED SKULL, compound, without dural penetration, operation for (AU 12 - 454/523) Fee: $635.00 Benefit: 75% $476.25: 85%/$26 $609.00
* ‡ + 7114	FRACTURED SKULL, compound or complicated, with dural penetration and brain laceration, operation for (AU 14 - 458/525) Fee: $745.00 Benefit: 75% $558.75: 85%/$26 $719.00
* + 7115	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (AU 16 - 460/527) Fee: $795.00 Benefit: 75% $596.25: 85%/$26 $769.00
†	**INTRACRANIAL NEOPLASMS**
7116	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (AU 27 - 471/542) Fee: $370.00 Benefit: 75% $277.50: 85%/$26 $344.00
* ‡ + 7117	INTRACRANIAL tumour or cyst, burr-hole and biopsy of, or drainage of, or both (AU 10 - 450/521) Fee: $345.00 Benefit: 75% $258.75: 85%/$26 $319.00
* + 7122	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (AU 18 - 462/529) Fee: $740.00 Benefit: 75% $555.00: 85%/$26 $714.00
* + 7123	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not covered by any other Item in this Part (AU 25 - 469/540) Fee: $1,055.00 Benefit: 75% $791.25: 85%/$26 $1,029.00

Item	Description
* ‡ + 7125	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour not covered by any other item in this Part (AU 25 - 469/540) **Fee:** $1,905.00 **Benefit:** 75% $1,428.75: 85%/$26 $1,879.00
* ‡ + 7126	PITUITARY TUMOUR, hypophysectomy or removal of by transcranial or transphenoidal approach (AU 25 - 469/540) **Fee:** $1,320.00 **Benefit:** 75% $990.00: 85%/$26 $1,294.00
* ‡ + 7130	ARACHNOIDAL CYST, craniotomy for (AU 15 - 459/526) **Fee:** $580.00 **Benefit:** 75% $435.00: 85%/$26 $554.00
* + 7135	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (AU 16 - 460/527) **Fee:** $530.00 **Benefit:** 75% $397.50: 85%/$26 $504.00
* ‡ + 7136	**CEREBROVASCULAR DISEASE** ANEURYSM, clipping or reinforcement of sac (AU 28 - 472/543) **Fee:** $1,900.00 **Benefit:** 75% $1,425.00: 85%/$26 $1,874.00
† 7137	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (AU 32 - 475/546) **Fee:** $1,900.00 **Benefit:** 75% $1,425.00: 85%/$26 $1,874.00
* ‡ 7147	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (AU 24 - 468/539) **Fee:** $855.00 **Benefit:** 75% $641.25: 85%/$26 $829.00
† 7149	ARTERIOVENOUS MALFORMATION, craniotomy and direct embolisation of (AU 32 - 475/546) **Fee:** $950.00 **Benefit:** 75% $712.50: 85%/$26 $924.00
* ‡ 7150	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (AU 10 - 450/521) **Fee:** $420.00 **Benefit:** 75% $315.00: 85%/$26 $394.00
† 7151	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (AU 40 - 479/550) **Fee:** $1,215.00 **Benefit:** 75% $911.25: 85%/$26 $1,189.00
† 7154	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery or saphenous vein graft (AU 32 - 475/546) **Fee:** $1,215.00 **Benefit:** 75% $911.25: 85%/$26 $1,189.00

Item	Description
* +	**INFECTION**
7155	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (AU 10 - 450/521) Fee: $345.00 Benefit: 75% $258.75: 85%/$26 $319.00
* + 7158	INTRACRANIAL ABSCESS, excision of (AU 17 - 461/528) Fee: $1,055.00 Benefit: 75% $791.25: 85%/$26 $1,029.00
* ‡ + 7159	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (AU 10 - 450/521) Fee: $530.00 Benefit: 75% $397.50: 85%/$26 $504.00
*	**CEREBRO-SPINAL FLUID CIRCULATION DISORDERS**
7160	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (AU 15 - 459/526) Fee: $610.00 Benefit: 75% $457.50: 85%/$26 $584.00
* ‡ 7161	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (AU 14 - 458/525) Fee: $610.00 Benefit: 75% $457.50: 85%/$26 $584.00
* ‡ 7162	LUMBAR SHUNT DIVERSION, insertion of (AU 13 - 457/524) Fee: $480.00 Benefit: 75% $360.00: 85%/$26 $454.00
* ‡ + 7163	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (AU 12 - 454/523) Fee: $350.00 Benefit: 75% $262.50: 85%/$26 $324.00
† 7164	THIRD VENTRICULOSTOMY (AU 15 - 459/526) Fee: $685.00 Benefit: 75% $513.75: 85%/$26 $659.00
† 7165	SUBTEMPORAL DECOMPRESSION (AU 26 - 470/541) Fee: $158.00 Benefit: 75% $118.50: 85%/$26 $134.30
† 7166	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (AU 6 - 407/513) Fee: $106.00 Benefit: 75% $79.50: 85%/$26 $90.10
* ‡ +	**CONGENITAL DISORDERS**
7167	MENINGOCELE, excision and closure of (AU 13 - 457/524) Fee: $460.00 Benefit: 75% $345.00: 85%/$26 $434.00
* ‡ 7168	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (AU 15 - 459/526) Fee: $675.00 Benefit: 75% $506.25: 85%/$26 $649.00

† 7169	ARNOLD-CHIARI MALFORMATION, decompression of (AU 35 - 493/564) **Fee:** $685.00 **Benefit:** 75% $513.75: 85%/$26 $659.00
† 7172	ENCEPHALOCOELE, excision and closure of (AU 34 - 492/563) **Fee:** $740.00 **Benefit:** 75% $555.00: 85%/$26 $714.00
† 7173	TETHERED CORD, release of, including lipomeningocoele or diastematomyelia (AU 35 - 493/564) **Fee:** $950.00 **Benefit:** 75% $712.50: 85%/$26 $924.00
* 7174	CRANIOSTENOSIS, operation for - single suture (AU 17 - 461/528) **Fee:** $480.00 **Benefit:** 75% $360.00: 85%/$26 $454.00
* + 7176	CRANIOSTENOSIS, operation for - more than one suture (AU 20 - 464/533) **Fee:** $635.00 **Benefit:** 75% $476.25: 85%/$26 $609.00
* ‡ 7177	**SPINAL DISORDERS** INTERVERTEBRAL DISC OR DISCS, laminectomy for exploration or removal of (AU 12 - 454/523) **Fee:** $635.00 **Benefit:** 75% $476.25: 85%/$26 $609.00
* ‡ 7179	RECURRENT DISC LESION OR SPINAL STENOSIS, laminectomy for - one level (AU 13 - 457/524) **Fee:** $725.00 **Benefit:** 75% $543.75: 85%/$26 $699.00
* ‡ 7180	SPINAL CANAL STENOSIS, laminectomy (multi-level), for treatment of (AU 16 - 460/527) **Fee:** $955.00 **Benefit:** 75% $716.25: 85%/$26 $929.00
* ‡ 7181	EXTRADURAL TUMOUR OR ABSCESS, laminectomy for (AU 12 - 454/523) **Fee:** $725.00 **Benefit:** 75% $543.75: 85%/$26 $699.00
* 7183	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots, with or without laminectomy (AU 16 - 460/527) **Fee:** $635.00 **Benefit:** 75% $476.25: 85%/$26 $609.00
† 7185	INTRADURAL LESION, laminectomy for, not covered by any other item in this Part (AU 13 - 457/524) **Fee:** $975.00 **Benefit:** 75% $731.25: 85%/$26 $949.00
† 7187	CRANIOCERVICAL JUNCTION LESION, transoral approach for (AU 29 - 473/544) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
* ‡ + 7188	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, laminectomy and radical excision of (AU 14 - 458/525) **Fee:** $1,320.00 **Benefit:** 75% $990.00: 85%/$26 $1,294.00

Item	Description
* ‡ 7189	POSTERIOR SPINAL FUSION, not covered by items 7191 and 7193 (AU 18 - 462/529) **Fee:** $725.00 **Benefit:** 75% $543.75: 85%/$26 $699.00
* + 7191	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (AU 18 - 462/529) **Fee:** $425.00 **Benefit:** 75% $318.75: 85%/$26 $399.00
* + 7193	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare **Fee:** $425.00 **Benefit:** 75% $318.75: 85%/$26 $399.00
* 7195	ANTERIOR INTERBODY SPINAL FUSION TO CERVICAL SPINE - one level (AU 14 - 458/525) **Fee:** $730.00 **Benefit:** 75% $547.50: 85%/$26 $704.00
† 7196	CERVICAL DISCECTOMY (ANTERIOR), without fusion (AU 19 - 463/531) **Fee:** $530.00 **Benefit:** 75% $397.50: 85%/$26 $504.00
* ‡ 7197	SPINE (EXCLUDING SACRUM), treatment of fracture of vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers (AU 9 - 443/518) **Fee:** $235.00 **Benefit:** 75% $176.25: 85%/$26 $209.00
* ‡ 7199	SPINE (EXCLUDING SACRUM), treatment of fracture of vertebral body, with involvement of cord (AU 9 - 443/518) **Fee:** $600.00 **Benefit:** 75% $450.00: 85%/$26 $574.00
* + 7200	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - one disc (AU 8 - 409/517) *(See para 10.33 of explanatory notes to this Part)* **Fee:** $210.00 **Benefit:** 75% $157.50: 85%/$26 $184.00
* 7208	BONE GRAFT TO SPINE with laminectomy and posterior interbody fusion - one level (AU 15 - 459/526) **Fee:** $830.00 **Benefit:** 75% $622.50: 85%/$26 $804.00
* 7209	BONE GRAFT TO SPINE with laminectomy and posterior interbody fusion - more than one level (AU 18 - 462/529) **Fee:** $1,140.00 **Benefit:** 75% $855.00: 85%/$26 $1,114.00
* 7211	BONE GRAFT TO SPINE, postero-lateral fusion (AU 14 - 458/525) **Fee:** $850.00 **Benefit:** 75% $637.50: 85%/$26 $824.00
* 7213	ANTERIOR INTERBODY SPINAL FUSION TO LUMBAR OR THORACIC SPINE - one level (AU 15 - 459/526) **Fee:** $850.00 **Benefit:** 75% $637.50: 85%/$26 $824.00

* 7214	ANTERIOR INTERBODY SPINAL FUSION TO LUMBAR OR THORACIC SPINE - more than one level (AU 15 - 459/526) **Fee:** $1,140.00 **Benefit:** 75% $855.00: 85%/$26 $1,114.00
† 7217	HYDROMELIA, plugging of obex for, with or without duroplasty (AU 25 - 469/540) **Fee:** $1,055.00 **Benefit:** 75% $791.25: 85%/$26 $1,029.00
* ‡ + 7218	HYDROMELIA, craniotomy and laminectomy for, with cavity packing and CSF shunt (AU 25 - 469/540) **Fee:** $975.00 **Benefit:** 75% $731.25: 85%/$26 $949.00
* ‡ + 7219	**SKULL RECONSTRUCTION** CRANIOPLASTY, reconstructive (AU 16 - 460/527) **Fee:** $635.00 **Benefit:** 75% $476.25: 85%/$26 $609.00
* ‡ + 7222	**EPILEPSY** CORPUS CALLOSUM, anterior section of, for epilepsy (AU 25 - 469/540) **Fee:** $1,160.00 **Benefit:** 75% $870.00: 85%/$26 $1,134.00
† 7223	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (AU 23 - 467/538) **Fee:** $975.00 **Benefit:** 75% $731.25: 85%/$26 $949.00
† 7224	HEMISPHERECTOMY for intractible epilepsy (AU 40 - 479/550) **Fee:** $1,425.00 **Benefit:** 75% $1,068.75: 85%/$26 $1,399.00
† 7225	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (AU 15 - 459/526) **Fee:** $345.00 **Benefit:** 75% $258.75: 85%/$26 $319.00
† 7226	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (AU 21 - 465/535) **Fee:** $695.00 **Benefit:** 75% $521.25: 85%/$26 $669.00
† 7227	**STEREOTACTIC PROCEDURES** STEREOTACTIC ANATOMICAL LOCALISATION in association with an intracranial operative procedure (AU 17 - 461/528) **Fee:** $595.00 **Benefit:** 75% $446.25: 85%/$26 $569.00
† 7228	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not covered by any other item in this Part (AU 17 - 461/528) **Fee:** $795.00 **Benefit:** 75% $596.25: 85%/$26 $769.00

* ‡	**MISCELLANEOUS**
7229	LEUCOTOMY for psychiatric disorder (AU 15 - 459/526) **Fee:** $600.00 **Benefit:** 75% $450.00: 85%/$26 $574.00
* 7232	OPTIC NERVE MENINGES, incision of (AU 14 - 458/525) **Fee:** $555.00 **Benefit:** 75% $416.25: 85%/$26 $529.00

PART 10 - OPERATIONS

DIVISION 13 - PLASTIC AND RECONSTRUCTIVE

Item	Description
†	**METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL AND AESTHETIC RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR**
8445	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (AU 7 - 408/514) **Fee:** $360.00 **Benefit:** 75% $270.00: 85%/$26 $334.00
† 8446	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to one defect, simple and small (AU 11 - 453/522) **Fee:** $400.00 **Benefit:** 75% $300.00: 85%/$26 $374.00
† 8447	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to one defect, (pectoralis major, latissimus dorsi, or similar large muscle) (AU 16 - 460/527) **Fee:** $690.00 **Benefit:** 75% $517.50: 85%/$26 $664.00
‡ 8448	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR to one defect, simple and small (AU 11 - 453/522) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
‡ 8449	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to one defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (AU 17 - 461/528) **Fee:** $420.00 **Benefit:** 75% $315.00: 85%/$26 $394.00
† 8451	MUSCLE OR MYOCUTANEOUS FLAP, delay of (AU 8 - 409/517) **Fee:** $200.00 **Benefit:** 75% $150.00: 85%/$26 $174.00
* 8453	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (AU 12 - 454/523) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
* 8455	ABRASIVE THERAPY, limited to one aesthetic area (AU 6 - 407/513) **Fee:** $118.00 **Benefit:** 75% $88.50: 85%/$26 $100.30
* 8456	ABRASIVE THERAPY to more than one aesthetic area (AU 7 - 408/514) **Fee:** $265.00 **Benefit:** 75% $198.75: 85%/$26 $239.00
‡ + 8458	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 7 - 408/514) **Fee:** $80.00 **Benefit:** 75% $60.00: 85%/$26 $68.00

Item	Description
‡ + 8462	ANGIOMA OF SKIN and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (AU 7 - 408/514) **Fee:** $86.00 **Benefit:** 75% $64.50: 85%/$26 $73.10
‡ + 8466	ANGIOMA OF FACIAL MUSCLE OR BREAST, large or involving deeper tissue, excision and suture of (AU 9 - 443/518) **Fee:** $160.00 **Benefit:** 75% $120.00: 85%/$26 $136.00
* 8467	ANGIOMA OF NECK, deep, excision of (AU 10 - 450/521) **Fee:** $750.00 **Benefit:** 75% $562.50: 85%/$26 $724.00
† 8471	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (AU 11 - 453/522) **Fee:** $160.00 **Benefit:** 75% $120.00: 85%/$26 $136.00
† 8473	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (AU 16 - 460/527) **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00
† 8475	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, neck, hand, thumb, finger or genitals, excision of (AU 16 - 460/527) **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00
‡ 8476	LYMPHOEDEMATOUS TISSUE of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (AU 15 - 459/526) **Fee:** $515.00 **Benefit:** 75% $386.25: 85%/$26 $489.00
‡ 8478	FOREIGN IMPLANT, (non biological), insertion of, for contour reconstruction for pathological deformity (AU 10 - 450/521) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
‡ 8480	SINGLE STAGE LOCAL FLAP, where indicated to repair one defect, simple and small, excluding flap for male pattern baldness (AU 7 - 408/514) **Fee:** $190.00 **Benefit:** 75% $142.50: 85%/$26 $164.00
* 8481	SINGLE STAGE LOCAL FLAP, where indicated to repair one defect, complicated or large, excluding flap for male pattern baldness (AU 10 - 450/521) **Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00
† 8483	SINGLE STAGE LOCAL FLAP where indicated to repair one defect, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (AU 12 - 454/523) **Fee:** $255.00 **Benefit:** 75% $191.25: 85%/$26 $229.00
8485	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (AU 11 - 453/522) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
@ 8486	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (AU 9 - 443/518) **Fee:** $156.00 **Benefit:** 75% $117.00: 85%/$26 $132.60

Item	Description
8487	DIRECT FLAP REPAIR, cross leg, first stage (AU 13 - 457/524) **Fee:** $675.00 **Benefit:** 75% $506.25: 85%/$26 $649.00
@ 8488	DIRECT FLAP REPAIR, cross leg, second stage (AU 10 - 450/521) **Fee:** $300.00 **Benefit:** 75% $225.00: 85%/$26 $274.00
8490	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (AU 7 - 408/514) **Fee:** $174.00 **Benefit:** 75% $130.50: 85%/$26 $148.00
8492	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (AU 7 - 408/514) **Fee:** $78.00 **Benefit:** 75% $58.50: 85%/$26 $66.30
8494	INDIRECT FLAP OR TUBED PEDICLE, formation of (AU 10 - 450/521) **Fee:** $295.00 **Benefit:** 75% $221.25: 85%/$26 $269.00
‡ + 8496	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (AU 8 - 409/517) **Fee:** $148.00 **Benefit:** 75% $111.00: 85%/$26 $125.80
8498	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (AU 10 - 450/521) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
8500	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (AU 8 - 409/517) **Fee:** $245.00 **Benefit:** 75% $183.75: 85%/$26 $219.00
‡ 8502	DIRECT, INDIRECT OR LOCAL FLAP, revision of (AU 7 - 408/514) **Fee:** $174.00 **Benefit:** 75% $130.50: 85%/$26 $148.00
‡ 8504	FREE GRAFTING (split skin) of a granulating area, small (AU 7 - 408/514) **Fee:** $136.00 **Benefit:** 75% $102.00: 85%/$26 $115.60
‡ 8508	FREE GRAFTING (split skin) of a granulating area, extensive (AU 11 - 453/522) **Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00
‡ 8512	*For items covering free grafting (split skin) to burns see Item 8688 to 8698* FREE GRAFTING (split skin) to one defect, including elective dissection, small (AU 8 - 409/517) **Fee:** $190.00 **Benefit:** 75% $142.50: 85%/$26 $164.00
† 8515	FREE GRAFTING (split skin) to one defect, including elective dissection, extensive (AU 11 - 453/522) **Fee:** $390.00 **Benefit:** 75% $292.50: 85%/$26 $364.00
‡ + 8516	FREE GRAFTING (split skin) as inlay graft to one defect including elective dissection using a mould (including insertion of, and removal of mould) (AU 11 - 453/522) **Fee:** $370.00 **Benefit:** 75% $277.50: 85%/$26 $344.00

† 8517	FREE GRAFTING (split skin) to one defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not covered by Items 8515 or 8516 (AU 8 - 409/517) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
‡ 8518	FREE GRAFTING (full thickness), to one defect, excluding grafts for male pattern baldness (AU 9 - 443/518) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
* 8519	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (AU 14 - 458/525) **Fee:** $725.00 **Benefit:** 75% $543.75: 85%/$26 $699.00
* 8521	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (AU 22 - 466/537) **Fee:** $1,350.00 **Benefit:** 75% $1,012.50: 85%/$26 $1,324.00
‡ 8522	SCAR, of face or neck, revision of, NOT MORE THAN 3 cm. IN LENGTH, where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 8 - 409/517) **Fee:** $146.00 **Benefit:** 75% $109.50: 85%/$26 $124.10
* 8523	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for reimplantation of limb or digit or free transfer of tissue (AU 38 - 477/548) **Fee:** $1,180.00 **Benefit:** 75% $885.00: 85%/$26 $1,154.00
8524	SCAR, of face or neck, revision of, MORE THAN 3 cm. IN LENGTH, where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 9 - 443/518) **Fee:** $196.00 **Benefit:** 75% $147.00: 85%/$26 $170.00
† 8525	SCAR, other than on face or neck, not more than 7 centimetres in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, as an independent procedure (AU 10 - 450/521) **Fee:** $124.00 **Benefit:** 75% $93.00: 85%/$26 $105.40
† 8526	SCAR, other than on face or neck, more than 7 centimetres in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, as an independent procedure (AU 12 - 454/523) **Fee:** $150.00 **Benefit:** 75% $112.50: 85%/$26 $127.50
† 8527	BREAST PROSTHESIS, removal of, as an independent procedure (AU 11 - 453/522) **Fee:** $184.00 **Benefit:** 75% $138.00: 85%/$26 $158.00
8528	MAMMAPLASTY, reduction (unilateral), with or without repositioning of nipple (AU 10 - 450/521) **Fee:** $600.00 **Benefit:** 75% $450.00: 85%/$26 $574.00

† 8529	FIBROUS CAPSULE SURROUNDING BREAST PROSTHESIS, excision or multiple incisions to, as an independent procedure (AU 10 - 450/521) **Fee:** $295.00 **Benefit:** 75% $221.25: 85%/$26 $269.00
‡ 8530	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to one breast (AU 10 - 450/521) *(See para 10.41 of explanatory notes to this Part)* **Fee:** $495.00 **Benefit:** 75% $371.25: 85%/$26 $469.00
‡ 8531	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (AU 9 - 443/518) **Fee:** $495.00 **Benefit:** 75% $371.25: 85%/$26 $469.00
‡ 8532	BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large myocutaneous flap, including repair of secondary skin defect, excluding repair of muscular aponeurotic layer (AU 20 - 464/533) *(See para 10.42 of explanatory notes to this Part)* **Fee:** $730.00 **Benefit:** 75% $547.50: 85%/$26 $704.00
8533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (AU 15 - 459/526) **Fee:** $830.00 **Benefit:** 75% $622.50: 85%/$26 $804.00
‡ 8534	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, insetting of breast flap, with closure of donor site or other similar procedure (AU 12 - 454/523) **Fee:** $305.00 **Benefit:** 75% $228.75: 85%/$26 $279.00
8536	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (AU 9 - 443/518) **Fee:** $710.00 **Benefit:** 75% $532.50: 85%/$26 $684.00
8537	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (AU 9 - 443/518) **Fee:** $410.00 **Benefit:** 75% $307.50: 85%/$26 $384.00
8538	NIPPLE OR AREOLA or both, reconstruction of by any technique (AU 10 - 450/521) *(See para 10.43 of explanatory notes to this Part)* **Fee:** $415.00 **Benefit:** 75% $311.25: 85%/$26 $389.00
† 8539	BREAST PROSTHESIS, replacement of, following medical complications, (including rupture, migration, or capsule formation) where new pocket is formed (AU 15 - 459/526) **Fee:** $465.00 **Benefit:** 75% $348.75: 85%/$26 $439.00

Item	Description
‡ 8540	DIGIT, transfer of digit or anatomical ray on vascular or neurovascular pedicle (complete procedure) (AU 16 - 460/527) **Fee:** $855.00 **Benefit:** 75% $641.25: 85%/$26 $829.00
* 8541	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not covered by any other item in this Part (AU 11 - 453/522) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
8542	NEUROVASCULAR ISLAND FLAP, or free transfer of tissue with vascular or neurovascular pedicle, including repair of secondary defect excluding flap for male pattern baldness (AU 15 - 459/526) **Fee:** $730.00 **Benefit:** 75% $547.50: 85%/$26 $704.00
8543	TISSUE EXPANSION not covered by Items 8536/8537 - insertion of tissue expansion unit and all attendances for subsequent expansion injections (AU 10 - 450/521) **Fee:** $710.00 **Benefit:** 75% $532.50: 85%/$26 $684.00
‡ 8544	MACRODACTYLY, surgical reduction of, each finger (AU 8 - 409/517) **Fee:** $220.00 **Benefit:** 75% $165.00: 85%/$26 $194.00
† 8545	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with any other Item in Part 10 including expansion injections and excluding treatment of male pattern baldness (AU 13 - 457/524) **Fee:** $194.00 **Benefit:** 75% $145.50: 85%/$26 $168.00
8546	FACIAL NERVE PARALYSIS, free fascia graft for (AU 12 - 454/523) **Fee:** $480.00 **Benefit:** 75% $360.00: 85%/$26 $454.00
‡ 8548	FACIAL NERVE PARALYSIS, muscle transfer for (AU 13 - 457/524) **Fee:** $555.00 **Benefit:** 75% $416.25: 85%/$26 $529.00
† 8549	FACIAL NERVE PALSY, excision of tissue for (AU 12 - 454/523) **Fee:** $184.00 **Benefit:** 75% $138.00: 85%/$26 $158.00
† 8550	LIPOSUCTION (suction assisted lipolysis) to one regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (AU 13 - 457/524) **Fee:** $420.00 **Benefit:** 75% $315.00: 85%/$26 $394.00
8551	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to one side of the face (AU 14 - 458/525) *(See para 10.44 of explanatory notes to this Part)* **Fee:** $590.00 **Benefit:** 75% $442.50: 85%/$26 $564.00
‡ 8552	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (AU 12 - 454/523) **Fee:** $320.00 **Benefit:** 75% $240.00: 85%/$26 $294.00

‡ 8553	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (AU 14 - 458/525) **Fee:** $375.00 **Benefit:** 75% $281.25: 85%/$26 $349.00
‡ @ 8554	MAXILLA, total resection of (AU 29 - 473/544) **Fee:** $600.00 **Benefit:** 75% $450.00: 85%/$26 $574.00
‡ @ 8556	MANDIBLE, total resection of both sides, including condylectomies where performed (AU 35 - 493/564) **Fee:** $465.00 **Benefit:** 75% $348.75: 85%/$26 $439.00
† 8557	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (AU 19 - 463/531) **Fee:** $465.00 **Benefit:** 75% $348.75: 85%/$26 $439.00
‡ 8560	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (AU 13 - 457/524) **Fee:** $390.00 **Benefit:** 75% $292.50: 85%/$26 $364.00
8568	MANDIBLE, hemi-mandibular reconstruction with bone graft, not associated with Item 8556 (AU 15 - 459/526) **Fee:** $550.00 **Benefit:** 75% $412.50: 85%/$26 $524.00
8570	MANDIBLE, condylectomy (AU 11 - 453/522) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
‡ 8582	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (AU 10 - 450/521) **Fee:** $390.00 **Benefit:** 75% $292.50: 85%/$26 $364.00
‡ 8584	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision, herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring, or, in respect of one of these conditions, the restoration of symmetry of the contralateral upper eyelid (AU 7 - 408/514) *(See para 10.45 of explanatory notes to this Part)* **Fee:** $156.00 **Benefit:** 75% $117.00: 85%/$26 $132.60
‡ 8585	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring, or, in respect of one of these conditions, the restoration of symmetry of the contralateral lower eyelid (AU 8 - 409/517) *(See para 10.45 of explanatory notes to this Part)* **Fee:** $215.00 **Benefit:** 75% $161.25: 85%/$26 $189.00
‡ 8586	PTOSIS (unilateral), correction of (AU 12 - 454/523) **Fee:** $515.00 **Benefit:** 75% $386.25: 85%/$26 $489.00
8588	ECTROPION OR ENTROPION, correction of (unilateral) (AU 9 - 443/518) **Fee:** $215.00 **Benefit:** 75% $161.25: 85%/$26 $189.00

8592	SYMBLEPHARON, grafting for (AU 8 - 409/517) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00
‡ 8594	RHINOPLASTY, correction of lateral or alar cartilages (AU 10 - 450/521) **Fee:** $340.00 **Benefit:** 75% $255.00: 85%/$26 $314.00
8596	RHINOPLASTY, correction of bony vault only (AU 10 - 450/521) **Fee:** $390.00 **Benefit:** 75% $292.50: 85%/$26 $364.00
8598	RHINOPLASTY - TOTAL, including correction of all bony and cartilaginous elements of the external nose (AU 12 - 454/523) **Fee:** $675.00 **Benefit:** 75% $506.25: 85%/$26 $649.00
† 8599	RHINOPLASTY involving nasal or septal cartilage graft (AU 14 - 458/525) **Fee:** $720.00 **Benefit:** 75% $540.00: 85%/$26 $694.00
‡ 8600	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (AU 13 - 457/524) **Fee:** $850.00 **Benefit:** 75% $637.50: 85%/$26 $824.00
8602	RHINOPLASTY, secondary revision of (AU 10 - 450/521) **Fee:** $98.00 **Benefit:** 75% $73.50: 85%/$26 $83.30
‡ 8604	RHINOPHYMA, shaving of (AU 9 - 443/518) **Fee:** $235.00 **Benefit:** 75% $176.25: 85%/$26 $209.00
* 8605	FACE, contour restoration of one region, using autogenous bone or cartilage graft (not covered by Item 8600) (AU 18 - 462/529) **Fee:** $850.00 **Benefit:** 75% $637.50: 85%/$26 $824.00
8606	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (AU 11 - 453/522) **Fee:** $335.00 **Benefit:** 75% $251.25: 85%/$26 $309.00
8608	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (AU 8 - 409/517) **Fee:** $345.00 **Benefit:** 75% $258.75: 85%/$26 $319.00
8612	CONGENITAL ATRESIA, reconstruction of external auditory canal (AU 11 - 453/522) **Fee:** $465.00 **Benefit:** 75% $348.75: 85%/$26 $439.00
‡ 8614	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (AU 8 - 409/517) **Fee:** $215.00 **Benefit:** 75% $161.25: 85%/$26 $189.00
8616	VERMILIONECTOMY (AU 8 - 409/517) **Fee:** $215.00 **Benefit:** 75% $161.25: 85%/$26 $189.00
8618	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (AU 11 - 453/522) **Fee:** $555.00 **Benefit:** 75% $416.25: 85%/$26 $529.00

8620	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (AU 4 - 405/509) **Fee:** $162.00 **Benefit:** 75% $121.50: 85%/$26 $137.70
‡ + 8622	CLEFT LIP, unilateral - primary repair, one stage, without anterior palate repair (AU 12 - 454/523) **Fee:** $360.00 **Benefit:** 75% $270.00: 85%/$26 $334.00
† 8623	CLEFT LIP, unilateral - primary repair, one stage, with anterior palate repair (AU 14 - 458/525) **Fee:** $450.00 **Benefit:** 75% $337.50: 85%/$26 $424.00
‡ + 8624	CLEFT LIP, bilateral - primary repair, one stage, without anterior palate repair (AU 14 - 458/525) **Fee:** $500.00 **Benefit:** 75% $375.00: 85%/$26 $474.00
† 8625	CLEFT LIP, bilateral - primary repair, one stage, with anterior palate repair (AU 16 - 460/527) **Fee:** $590.00 **Benefit:** 75% $442.50: 85%/$26 $564.00
† 8627	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (AU 10 - 450/521) **Fee:** $174.00 **Benefit:** 75% $130.50: 85%/$26 $148.00
‡ + 8628	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (AU 10 - 450/521) **Fee:** $200.00 **Benefit:** 75% $150.00: 85%/$26 $174.00
‡ + 8630	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (AU 12 - 454/523) **Fee:** $325.00 **Benefit:** 75% $243.75: 85%/$26 $299.00
† 8631	CLEFT LIP, primary columella lengthening procedure, bilateral (AU 10 - 450/521) **Fee:** $305.00 **Benefit:** 75% $228.75: 85%/$26 $279.00
‡ + 8632	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (AU 12 - 454/523) **Fee:** $550.00 **Benefit:** 75% $412.50: 85%/$26 $524.00
† 8633	CLEFT LIP reconstruction using full thickness flap (Abbe or similar), second stage (AU 8 - 409/517) **Fee:** $200.00 **Benefit:** 75% $150.00: 85%/$26 $174.00
‡ + 8640	CLEFT PALATE, primary repair (AU 14 - 458/525) **Fee:** $520.00 **Benefit:** 75% $390.00: 85%/$26 $494.00
‡ + 8644	CLEFT PALATE, secondary repair, closure of fistula using local flaps (AU 13 - 457/524) **Fee:** $325.00 **Benefit:** 75% $243.75: 85%/$26 $299.00

+ 8648	CLEFT PALATE, secondary repair, lengthening procedure (AU 12 - 454/523) **Fee:** $370.00 **Benefit:** 75% $277.50: 85%/$26 $344.00
† 8655	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 16 - 460/527) **Fee:** $725.00 **Benefit:** 75% $543.75: 85%/$26 $699.00
‡ + 8656	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (AU 15 - 459/526) **Fee:** $520.00 **Benefit:** 75% $390.00: 85%/$26 $494.00
† 8657	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 20 - 464/533) **Fee:** $920.00 **Benefit:** 75% $690.00: 85%/$26 $894.00
‡ 8658	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (AU 14 - 458/525) *(See para 10.46 of explanatory notes to this Part)* **Fee:** $645.00 **Benefit:** 75% $483.75: 85%/$26 $619.00
‡ 8660	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (AU 18 - 462/529) *(See para 10.46 of explanatory notes to this Part)* **Fee:** $820.00 **Benefit:** 75% $615.00: 85%/$26 $794.00
‡ 8662	MANDIBLE or MAXILLA, OSTEOTOMIES or OSTEECTOMIES of, involving THREE OR MORE such procedures on the ONE JAW, including transposition of nerves and vessels and bone grafts taken from the same site (AU 22 - 466/537) *(See para 10.46 of explanatory notes to this Part)* **Fee:** $935.00 **Benefit:** 75% $701.25: 85%/$26 $909.00
‡ 8664	MANDIBLE OR MAXILLA, OSTEOTOMIES OR OSTEECTOMIES of, involving TWO such procedures of each JAW, including transposition of nerves and vessels and bone grafts taken from the same site (AU 26 - 470/541) *(See para 10.46 of explanatory notes to this Part)* **Fee:** $1,070.00 **Benefit:** 75% $802.50: 85%/$26 $1,044.00
‡ 8666	MANDIBLE OR MAXILLA, COMPLEX BILATERAL OSTEOTOMIES or OSTEECTOMIES of involving THREE or MORE such procedures of ONE JAW and TWO such procedures of the OTHER JAW, INCLUDING GENIOPLASTY (when performed) and transposition of nerves and vessels and bone grafts taken from the same site (AU 32 - 475/546) *(See para 10.46 of explanatory notes to this Part)* **Fee:** $1,180.00 **Benefit:** 75% $885.00: 85%/$26 $1,154.00

‡ 8668	MANDIBLE or MAXILLA, COMPLEX BILATERAL OSTEOTOMIES or OSTEECTOMIES of, involving THREE or MORE such procedures of EACH JAW, INCLUDING GENIOPLASTY (when performed) and transposition of nerves and vessels and bone grafts taken from the same site (AU 34 - 492/563) *(See para 10.46 of explanatory notes to this Part)* **Fee:** $1,285.00 **Benefit:** 75% $963.75: 85%/$26 $1,259.00
‡ 8670	GENIOPLASTY, including transposition of nerves and bone grafts taken from the same site (AU 10 - 450/521) *(See para 10.47 of explanatory notes to this Part)* **Fee:** $500.00 **Benefit:** 75% $375.00: 85%/$26 $474.00
‡ 8672	GENIOPLASTY associated with Item 8655, 8657, 8658, 8660, 8662, 8664, 8674 or 8686 (AU 8 - 409/517) *(See para 10.47 of explanatory notes to this Part)* **Fee:** $290.00 **Benefit:** 75% $217.50: 85%/$26 $264.00
† 8674	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving three or more such procedures on the ONE JAW, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 24 - 468/539) **Fee:** $1,050.00 **Benefit:** 75% $787.50: 85%/$26 $1,024.00
+ 8675	HYPERTELORISM, correction of, intra-cranial (AU 47 - 497/565) **Fee:** $1,670.00 **Benefit:** 75% $1,252.50: 85%/$26 $1,644.00
8676	HYPERTELORISM, correction of, sub-cranial (AU 26 - 470/541) **Fee:** $1,280.00 **Benefit:** 75% $960.00: 85%/$26 $1,254.00
‡ 8677	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (AU 30 - 474/545) **Fee:** $1,165.00 **Benefit:** 75% $873.75: 85%/$26 $1,139.00
‡ 8678	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of one orbit, intra-cranial (AU 35 - 493/564) **Fee:** $1,165.00 **Benefit:** 75% $873.75: 85%/$26 $1,139.00
‡ 8679	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of one orbit, extra-cranial (AU 18 - 462/529) **Fee:** $855.00 **Benefit:** 75% $641.25: 85%/$26 $829.00
‡ 8680	FRONTO-ORBITAL ADVANCEMENT, UNILATERAL (AU 19 - 463/531) **Fee:** $655.00 **Benefit:** 75% $491.25: 85%/$26 $629.00
8681	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition - (bilateral fronto-orbital advancement) (AU 39 - 478/549) **Fee:** $1,110.00 **Benefit:** 75% $832.50: 85%/$26 $1,084.00

‡ 8682	GLENOID FOSSA, SYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (AU 19 - 463/531) **Fee:** $1,095.00 **Benefit:** 75% $821.25: 85%/$26 $1,069.00
‡ 8683	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (AU 15 - 459/526) **Fee:** $590.00 **Benefit:** 75% $442.50: 85%/$26 $564.00
† 8684	OSSEO-INTEGRATION PROCEDURE - extra oral, implantation of titanium fixture (AU 20 - 464/533) **Fee:** $335.00 **Benefit:** 75% $251.25: 85%/$26 $309.00
† 8685	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment (AU 16 - 460/527) **Fee:** $124.00 **Benefit:** 75% $93.00: 85%/$26 $105.40
† 8686	MANDIBLE OR MAXILLA, osteotomies or oteectomies of, involving TWO such procedures of EACH JAW, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 28 - 472/543) **Fee:** $1,205.00 **Benefit:** 75% $903.75: 85%/$26 $1,179.00
† 8687	MANDIBLE OR MAXILLA, complex bilateral osteotomies or osteectomies of, involving THREE or MORE such procedures of ONE JAW and TWO such procedures of the OTHER JAW, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 34 - 492/563) **Fee:** $1,325.00 **Benefit:** 75% $993.75: 85%/$26 $1,299.00
† 8688	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (AU 8 - 409/517) **Fee:** $300.00 **Benefit:** 75% $225.00: 85%/$26 $274.00
† 8689	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (AU 10 - 450/521) **Fee:** $400.00 **Benefit:** 75% $300.00: 85%/$26 $374.00
† 8690	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (AU 12 - 454/523) **Fee:** $550.00 **Benefit:** 75% $412.50: 85%/$26 $524.00
† 8691	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (AU 14 - 458/525) **Fee:** $600.00 **Benefit:** 75% $450.00: 85%/$26 $574.00
† 8692	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more of total body surface (AU 16 - 460/527) **Fee:** $650.00 **Benefit:** 75% $487.50: 85%/$26 $624.00

Item	Description
† 8693	FREE GRAFTING (split skin) to burns, including excision of burnt tissue, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (AU 18 - 462/529) **Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00
† 8694	FREE GRAFTING (xenograft or homograft split skin) to burns including excision of burnt tissue - involving not more than 3 per cent of total body surface (AU 13 - 457/524) **Fee:** $220.00 **Benefit:** 75% $165.00: 85%/$26 $194.00
† 8695	FREE GRAFTING (xenograft or homograft split skin) to burns including excision of burnt tissue - involving 3 per cent or more but less than 6 per cent of total body surface (AU 15 - 459/526) **Fee:** $320.00 **Benefit:** 75% $240.00: 85%/$26 $294.00
† 8696	FREE GRAFTING (xenograft or homograft split skin) to burns including excision of burnt tissue - involving 6 per cent or more but less than 9 per cent of total body surface (AU 17 - 461/528) **Fee:** $470.00 **Benefit:** 75% $352.50: 85%/$26 $444.00
† 8697	FREE GRAFTING (xenograft or homograft split skin) to burns including excision of burnt tissue - involving 9 per cent or more but less than 12 per cent of total body surface (AU 19 - 463/531) **Fee:** $520.00 **Benefit:** 75% $390.00: 85%/$26 $494.00
† 8698	FREE GRAFTING (xenograft or homograft split skin) to burns including excision of burnt tissue - involving 12 per cent or more of total body surface (AU 21 - 465/535) **Fee:** $580.00 **Benefit:** 75% $435.00: 85%/$26 $554.00
† 8699	MANDIBLE OR MAXILLA, complex bilateral osteotomies or osteectomies of, involving THREE or MORE such procedures of EACH JAW, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 36 - 476/547) **Fee:** $1,440.00 **Benefit:** 75% $1,080.00: 85%/$26 $1,414.00

CONVERSION LISTS

Vascular

OLD	NEW	OLD	NEW	OLD	NEW
924	4793	4705	{4703		{4673
3004(153)	4765		{4704		{4674
4633	4620		{4707	4792	4670
4637	4621		{4708	4794	{4684
4641	4624		{4710		{4685
4649	4625		{4711		{4686
4651	4623		{4712		{4687
4655	4627		{4713	4798	{4668
4658	4628	4709	{4697		{4675
4662	4629		{4714		{4676
4664	4632		{4716		{4677
4665	4803	4721	4797		{4680
4688	4746	4738	4719		{4681
4690	{4742	4744	4639		{4694
	{4743	4749	{4642	4801	{4770
4693	{4728		{4643		{4776
	{4729	4754	{4644	4802	4777
	{4730		{4645	4808	4777
	{4731		{4647	4812	4780
	{4732		{4648	4813	4835
	{4734		{4652	4814	4836
4696	{4735		{4657	4817	{4779
	{4736		{4663		{4781
	{4737	4755	{4653	4822	4786
4699	{4752		{4659	4823	4787
	{4753	4766	{4819	4824	4788
	{4757	4778	{4723	7376	{4820
4702	{4748		{4725		{4821
	{4750	4784	4724	8158	4761
	{4751	4789	{4726	8159	4760
4705	{4700		{4727	8161	4759
	{4701	4791	{4672		

Neurosurgical

OLD	NEW	OLD	NEW	OLD	NEW
3004(160)	{7217	7120	7095	7170	{7080
	{7218	7121	7096		{7109
3004(161)	7222	7129	7097	7171	7083
3004(186)	7090	7133	7100	7175	7107
3004(190)	7094	7138	7098	7178}	7106
3004(244)	7092	7140	7102	7182}	
3004(255)	7232	7141	{7101	7184	7073
4829	7091		{7108	7186	7074
4830	7093	7143	7103	7190	{7075
7079	7077	7148}	7104		{7076
7081	7078	7152}		7192	7117
7085	7070	7153	7084	7194	7122
7089	7071	7156	7105	7198	7123
7099	7072	7157	7082	7203	7125

(Neurosurgical Cont'd)

OLD	NEW	OLD	NEW	OLD	NEW
7204	7126	7312	{7227	7361	7191
7212	7110		{7228	7365	7193
7216	7111	7314	{7160	7370	7183
7231	7112	7316	7161	7373	7200
7240	7113	7318	7163	7381	7087
7244	7114	7320	7162	7793	7197
7248	7115	7324	7174	7798	7199
7251	7219	7326	7176	7945	7211
7265	{7136	7328	7130	7947	7195
	{7137	7331	7177	7957	7213
7270	7147	7336	7179	7961	7214
7274	7150	7338	7180	7967	7208
7279	7135	7341	7181	7969	7209
7283	7158	7346	{7088	8442	7167
7287	7155		{7185	8444	7168
7291	7159	7353	7188		
7298	7229	7355	7189		

Plastic and Reconstructive

OLD	NEW	OLD	NEW	OLD	NEW
4695	8519	8510	{8691	8622	{8622
4756	8521		{8692		{8623
4764	8523	8511	{8694	8624	{8624
8448	{8445		{8695		{8625
	{8448		{8696	8628	{8627
8449	{8446		{8697		{8628
	{8447		{8698	8630	{8630
	{8449	8512	{8512		{8631
	{8451		{8517	8632	{8632
8450	8453	8516	{8515		{8633
8452	8455		{8516	8658	{8655
8454	8456	8522	{8522		{8658
8470	8471		{8525	8660	{8657
8472	{8473		{8526		{8660
	{8475	8535	8541	8662	{8662
8474	8467	8543	{8543		{8674
8484	{8481		{8545	8664	{8664
	{8483	8556	{8556		{8686
8509	{8688		{8557	8666	{8666
	{8689	8598	{8598		{8687
	{8693		{8599	8668	{8668
8510	{8690	8601	8605		{8699

DIA DIAGNOSTIC IMAGING SERVICES IN RELATION TO MEDICARE BENEFITS

DIA.1 **Introduction**

DIA.2 **Services Rendered "On Behalf Of" Medical Practitioners**

Medicare Benefits Attracted	DIA.2.1

DIA.3 **Basic Requirements**

General rule for Medicare Eligibility	DIA.3.1
Referral to Specified Practitioner Not Required	DIA.3.2
Request for More than One Service	DIA.3.3

DIA.4 **Exemptions from Basic Requirements**

General Provision	DIA.4.1
Specialists	DIA.4.2
Remote Area Exemption	DIA.4.3
Emergencies	DIA.4.4
Lost Requests	DIA.4.5
Additional Necessary Services	DIA.4.6
Pre-existing Diagnostic Imaging Practices	DIA.4.7

DIA.5 **Medicare Benefits Not Payable**

Medicare Benefits in Relation to Diagnostic Imaging Services Rendered in Contravention of State or Territory Laws	DIA.5.1
Medicare Benefits Not Payable in Respect of Services Rendered by Disqualified Practitioners	DIA.5.2
Notification of Contraventions of Certain State and Territory Laws to Relevant Authorities	DIA.5.3

DIB DIAGNOSTIC IMAGING SERVICES REQUESTS

DIB.1 **Form etc. of Request**

Details of Services Requested	DIB.1.1
Contravention of Request Requirements	DIB.1.2
Details Required on Accounts, Receipts and Medicare Assignment of Benefits Forms	DIB.1.3
Retention of Requests etc.	DIB.1.4
Other Records of Diagnostic Imaging Services	DIB.1.5

DIC REMOTE AREA EXEMPTIONS

DIC.1 **Remote Areas**

Designation of Remote Areas	DIC.1.1
Application for Remote Area Exemption	DIC.1.2
Request for Further Information	DIC.1.3

	Grant of Remote Area Exemption	DIC.1.4
	Restrictions on Remote Area Exemption	DIC.1.5
	Refusal of Application	DIC.1.6
	Deemed Refusal for Review Purposes	DIC.1.7
	Duration of Remote Area Exemption	DIC.1.8
	Renewal of Exemption	DIC.1.9
	Revocation of Exemption	DIC.1.10
DID	**REVIEW OF DECISIONS**	
DID.1	**Administrative Appeals Tribunal**	
	Review by Administrative Appeals Tribunal	DID.1.1
	Statements to Accompany Notification of Decisions	DID.1.2
DIE	**PROHIBITED PRACTICES**	
DIE.1	**Prohibited Diagnostic Imaging Practices**	
DIF	**POSSIBLE PROHIBITED PRACTICES**	
DIF.1	**Notice of Possible Breaches**	
	Minister to Give Notice	DIF.1.1
	Minister to Consider Submissions	DIF.1.2
	Minister May Take Further Action	DIF.1.3
DIG	**MEDICARE PARTICIPATION REVIEW COMMITTEE**	
DIG.1	**Chairman to Establish Committee**	
	Establishment of Committee	DIG.1.1
	Composition of Committees	DIG.1.2
	Provision of Information to Person	DIG.1.3
	Committee may add Parties to Proceedings	DIG.1.4
	Written Notice to Persons	DIG.1.5
	Committee Determinations	DIG.1.6
	Nature of Disqualification	DIG.1.7
	Specification of Period of Disqualification	DIG.1.8
	Determination of Services	DIG.1.9
	Revocation of Remote Area Exemption	DIG.1.10
	Recovery of Benefits Paid	DIG.1.11
	EXPLANATORY NOTES	
DIH	**ULTRASOUND**	
DIH.1	**Ultrasonic Cross-sectional Echography**	
	Examination of Practitioner's Patient	DIH.1.1
	Benefit Payable	DIH.1.2

DIH.2 **Routine Ultrasonic Scanning**

Termination of Pregnancy DIH.2.1
Details of referral arrangements DIH.2.2

DIH.3 **Investigations of Vascular Disease**

Fees Payable DIH.3.1

DII COMPUTERISED TOMOGRAPHY

DII.1 **General**

Separate Items DII.1.1

DII.2 **Scan of More Than One Area**

Common Combinations- Benefits DII.2.1

DII.3 **CT Scan of Temporal Bones With Air Study**

Associated Brain Scan DII.3.1

DII.4 **CT Scan of Spine with Intrathecal Contrast Medium**

Spine Scan with Contrast Medium DII.4.1

DII.5 **CT Scan of Extremities**

Scan of Extremities - Benefits DII.5.1

DII.6 **CT Scan of Multiple Regions**

Multiple Region Scan Benefits DII.6.1

DIJ DIAGNOSTIC RADIOLOGY

DIJ.1 **General**

Benefits DIJ.1.1

DIJ.2 **Films - exposure of more than one**

Film Use - Benefits DIJ.2.1

DIJ.3 **Comparison X-Rays - Limbs**

Comparison X-Rays - Benefits DIJ.3.1

DIJ.4 **Plain Abdominal Film**

Plain Abdominal Film - Benefits DIJ.4.1

DIJ.5	**Radiography of the Breast**	
	Benefits for referral in specific circumstances	DIJ.5.1
DIK	**MAGNETIC RESONANCE IMAGING**	
DIK.1	**General**	
	Benefits	DIK.1.1
DIL	**NUCLEAR MEDICINE IMAGING**	
DIL.1	**General**	
	Fee Structure	DIL.1.1
	"C" Schedule Fees	DIL.1.2
	"NC" Schedule Fees	DIL.1.3
	Computer Requirements	DIL.1.4
	Benefits	DIL.1.5
	Additional Benefits	DIL.1.6
DIL.2	**Radiopharmaceuticals**	
	Radiopharmaceuticals - Schedule Fees	DIL.2.1
DIL.3	**Study of region or organ not covered by any other item in this part (items 8873/74)**	
	Benefits	DIL.3.1

DIA DIAGNOSTIC IMAGING SERVICES IN RELATION TO MEDICARE BENEFITS

DIA.1 Introduction

In December 1990 Royal assent was given to legislation imposing certain conditions on the payment of Medicare benefits for diagnostic imaging services and prohibiting certain practices in the provision of those services. The services covered by this legislation, which comes into effect on 1 May 1991, are diagnostic radiology, CT scanning, ultrasound, magnetic resonance imaging and nuclear scanning.

The legislation, which is designed to effect an "arms length" referral arrangement in the provision of diagnostic imaging services, reflects the outcome of a review of the arrangements governing the provision of those services. The review involved extensive consultation with relevant professional organisations.

The principal feature of the legislation is that, except in certain circumstances, Medicare benefits are only payable for a diagnostic service if it is rendered following a written request for that service by another medical practitioner. For X-rays of the head the requesting practitioner may also be a dental practitioner, and for X-rays of the spine the requesting practitioner may also be a chiropractor.

To help in defining a diagnostic imaging service, a separate Diagnostic Imaging Services Table has been established. This Table includes the following services which were previously part of the Medicare Benefits Schedule of General Medical Services:

(i) Ultrasound items 791, 793 and 794 of Division 2 of Part 6, item 913 of Division 8 of Part 6, and items 990 to 999 of Division 9 of Part 6;

(ii) Part 7A - Computerised Tomography;

(iii) Part 8 - Diagnostic Radiology (formerly known as Radiological Services);

(iv) Part 9A - Magnetic Resonance Imaging; and

(v) Nuclear Medicine Imaging - excluding items 8701 to 8726 inclusive and items 8880 to 8886 inclusive (formerly known as Nuclear Medicine).

Items 8701 to 8726 and items 8880 to 8886 of Part 11 of the Medicare Benefits Schedule have been retained in the medical services table as a part named "Nuclear Medicine (Non-Imaging)".

The items of service which are subject to the written request requirement are classified as "R-type" (requested) services and are identified in the Diagnostic Imaging Services Table with the symbol "(R)" after the item description.

The items of service not subject to the request requirement are classified as "NR-type" (not requested) services and are identified with the symbol "(NR)" after the item description.

The "NR-type" items of service are ultrasound items 791 and 794, all items which were previously designated "G" services in Part 8 of the the Medicare Benefits Schedule Book, and the items in former Division 16 of Part 8. All other diagnostic imaging services are classified "R-type" services. The items in former Division 16 of Part 8 have not been classified as "R-type" services because this would require that there be a written request for the preparation items as well as the particular service to which it is related.

DIA.2 Services Rendered "On Behalf Of" Medical Practitioners

DIA.2.1 Medicare Benefits Attracted

Diagnostic imaging services attract Medicare benefits if the service is rendered by:

(i) a medical practitioner;
(ii) a person employed by a medical practitioner; or
(iii) a person employed by a hospital or other institution when acting under the supervision of a medical practitioner in accordance with accepted medical practice.

Benefits are not payable, for example, when a medical practitioner refers patients to self-employed paramedical personnel, such as radiographers or other persons who either bill the patient or the practitioner requesting the service.

DIA.3 Basic requirements

DIA.3.1 General rule for Medicare eligibility

Except in circumstances detailed below, a Medicare benefit is not payable for a diagnostic imaging service unless, prior to commencing the relevant service, the providing practitioner receives a signed and dated written request from a referring practitioner who determined that the service was necessary.

DIA.3.2 Referral to specified practitioner not required

It is not necessary that a written request for a diagnostic imaging service be addressed to a particular practitioner or that, if the request is addressed to a particular practitioner, the service must be rendered by that practitioner.

DIA.3.3 Request for more than one service

A practitioner may use a single request to order a number of diagnostic imaging services. However, all services provided under this request must be rendered within seven days after the rendering of the first service.

DIA.4 Exemptions from basic requirements

DIA.4.1 General Provision

The exemptions from the general written request requirements detailed below only apply to those "R-type" items of service for which there are no corresponding "NR-type" item of service.

DIA.4.2 Specialists

A written request is not required for the payment of Medicare benefits when the diagnostic imaging service is provided by or on behalf of a specialist (other than a specialist in diagnostic radiology) in the course of that specialist practising his or her specialty and after determining that the service was necessary. See section DIB.1.3 for details required on accounts.

DIA.4.3 Remote Area Exemption

A written request is not required for the payment of Medicare benefits for an "R-type" diagnostic imaging service rendered by a medical practitioner in a remote area, provided:

- the "R-type" service is not one for which there is a corresponding "NR-type" service; and

- the medical practitioner rendering the service has been granted a remote area exemption for that service.

Further information regarding the remote area exemption is set out in section DIC of these explanatory notes. See section DIB.1.3 for details required on accounts.

DIA.4.4 Emergencies

The written request requirement does not apply if the providing practitioner determined that, because the need for the service arose in an emergency, the service should be performed as quickly as possible. See section DIB.1.3 for details required on accounts.

DIA.4.5 Lost Requests

The written request requirement does not apply where:

- the person who received the diagnostic imaging service or someone acting on that person's behalf claimed that a medical practitioner, dentist or chiropractor had made a written request for such a service but that the request had been lost; and

- the provider of the diagnostic imaging service or that practitioner's agent or employee obtained confirmation from the requesting practitioner.

In respect of requests by dentists and chiropractors, the lost request exemption is applicable only to radiographic examinations of the head and the spine respectively. For details required on accounts, see section DIB.1.3.

DIA.4.6 Additional Necessary Services

A written request is not required for a diagnostic imaging service if that service was rendered after one which had been formally requested and the providing practitioner had determined that, on the basis of the results obtained from the requested service, that an additional service was necessary.

For details required on accounts, see section DIB.1.3.

DIA.4.7 Pre-existing Diagnostic Imaging Practices

The legislation provides for exemption from the written request requirement for services provided by practitioners who have operated pre-existing diagnostic imaging practices. To qualify for this "grandparent" exemption the providing practitioner must:

(a) be treating his or her own patient;
(b) have determined that the service was necessary;
(c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
(d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent"exemption were rendered; and
(e) render the service before 1 January 1993 as the legislation provides that, from that date, the exemption provision is automatically repealed.

The above exemption applies to a limited number of services. At the time these notes were prepared these services remained the subject of negotiation with relevant professional organisations. However, all practitioners should have received notification of these services through a "Dear Doctor" letter which sets out the basic requirements of the new diagnostic imaging services provisions.

For details required on accounts, see section DIB.1.3.

DIA.5 Medicare Benefits Not Payable

DIA.5.1 Medicare Benefits in Relation to Diagnostic Imaging Services Rendered in Contravention of State or Territory Laws

Where a diagnostic imaging service is rendered by or on behalf of a medical practitioner and the rendering of that service by the doctor or any other person contravenes a State or Territory law relating directly or indirectly to the use of diagnostic imaging procedures or equipment, Medicare benefits are not payable.

DIA.5.2 Medicare Benefit Not Payable in Respect of Services Rendered by Disqualified Practitioners

Medicare benefits are not payable for a diagnostic imaging service if, at the time the service was rendered, the providing practitioner or the practitioner on whose behalf the service was rendered was disqualified fully or partially from the Medicare benefits arrangements.

DIA.5.3 Notification of Contraventions of Certain State and Territory Laws to Relevant Authorities.

The General Manager of the Health Insurance Commission may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

DIB DIAGNOSTIC IMAGING SERVICES REQUESTS

DIB.1 Form etc. of Request

DIB.1.1 Details of Services Requested

A written request for a diagnostic imaging service does not have to be in any particular form. However, the legislation provides that a request must contain sufficient information, in terms that are generally understood by the profession, to clearly identify the item of service requested. Responsibility for the adequacy of requesting details rests with the requesting practitioner.

DIB.1.2 Contravention of Request Requirements

A practitioner who, without reasonable excuse, makes a request for a diagnostic imaging service that does not include the required information in his or her request or in a request made on his or her behalf is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

A medical practitioner who renders "R-type" diagnostic imaging services and who, without reasonable excuse, provides either directly or indirectly to a requesting practitioner a document to be used in the making of a request which would contravene the request information requirements is guilty of an offense under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

DIB.1.3 Details Required on Accounts, Receipts and Medicare Assignment of Benefits Forms

In addition to the normal particulars of the patient, the services performed and the fees charged, the details which are to be entered on accounts or receipts, and Medicare assignment of benefits forms in respect of diagnostic imaging services are as follows:

- For "R-type" (requested) services and services rendered subsequent to lost requests, the account or receipt or the Medicare assignment form must indicate the date of the request and the name and provider number, or the name and address, of the requesting practitioner.

- For a specialist service, a remote area service, an additional service or a pre-existing diagnostic imaging practice service, the account etc. must be endorsed with the letters "SD" to indicate that the service was self determined.

- For emergencies, the account etc. must be endorsed "emergency".

- In respect of lost requests the account etc. must be endorsed "lost request".

DIB.1.4 Retention of Requests etc.

A medical practitioner who has rendered an R-type diagnostic imaging service in response to a written request must retain that request for the period of 18 months commencing on the day on which the service was rendered.

A medical practitioner must, if requested by the General Manager of the Health Insurance Commission, produce to an officer of the Commission written requests retained by that practitioner for an "R-type" diagnostic imaging service as soon as practicable but in any case no later than the end of the day after the day on which the General Manager's request was made.

The officer of the Health Insurance Commission is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

A medical practitioner who, without reasonable excuse, fails to comply with the above requirements is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

DIB.1.5 Other Records of Diagnostic Imaging Services

Providers of diagnostic imaging services must keep records of diagnostic imaging services in a manner that facilitates retrieval on the basis of the patient's name and date of service.

These records must include the report by the providing practitioner on the diagnostic imaging service.

For services rendered after a lost request, the records must include words to the effect that the request was lost but confirmed by the requesting practitioner and the manner of confirmation, e.g. how and when.

For emergency services, the records must indicate the nature of the emergency.

Medical practitioners must retain records of R-type diagnostic imaging services for a period of 18 months commencing on the day on which the service was rendered.

If requested by the General Manager of the Health Insurance Commission, records retained by a providing practitioner must be produced to an officer of the Commission as soon as practicable but in any event within seven days after the day the General Manager requests the production of those records.

Officers of the Health Insurance Commission may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions

is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of $1000.

DIC REMOTE AREA EXEMPTIONS

DIC.1 Remote Areas

DIC.1.1 Designation of Remote Areas

For remote area exemption purposes a remote area is one that is:

(a) more than 30 kilometres by road from a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and

(b) more than 30 kilometres by road from a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

Consideration may also be given to applications for remote area exemptions which do not satisfy the above distance criteria if the applicant can demonstrate that his or her practice location is of sufficient distance from a hospital or facility of the kind mentioned in (a) and (b) to warrant it being declared to be remote by virtue of the physical or financial hardship that not declaring it to be remote would cause to a significant proportion of patients in the area.

As is explained in section DIC.1.5, a remote area exemption may be restricted to certain services.

DIC.1.2 Application for Remote Area Exemption

A medical practitioner who believes that he or she qualifies for exemption under the remote area definition and wishes to apply for such an exemption should make application, using the approved form (which is obtainable from the Health Insurance Commission), to the General Manager, Health Insurance Commission, c/o Manager, Eligibility and Benefits, PO Box 9822 in the Capital city in his or her State.

The form requires that the applicant provide the following details:

(a) the practitioner's name, address and practice location;
(b) a statement setting out the services for which exemption is sought;
(c) the reasons for seeking the exemption;
(d) the name, location, and distance from the applicant's practice, of the nearest radiology facility under the direction of a specialist radiologist; and
(e) if any arrangements exist for the provision of services by a visiting radiologist, the nature of those arrangements.

DIC.1.3 Request for Further Information

An applicant for remote area exemption may be requested by the Minister for Community Services and Health to provide additional information within 60 days of a remote area exemption application having been made.

DIC.1.4 Grant of Remote Area Exemption

The applicant must be granted a remote area exemption if the the Minister is satisfied:

(a) the applicant provided the required information;
(b) the applicant's practice is located in a remote area; and
(c) the facilities for rendering "R-type" diagnostic imaging services in the area in which

the applicant's practice is located, including any visiting facilities, are such that, were the formal written request requirement to apply to the rendering of those services, patients in the area would suffer physical or financial hardship.

DIC.1.5 Restrictions on Remote Area Exemption

Where the physical or financial hardship would only apply to the rendering of a limited range of diagnostic imaging services, the notice granting exemption from the written request requirements may restrict the remote area exemption to those services.

If a limited exemption is granted, the applicant will be provided in writing with the reasons for that restriction.

The person to whom a remote area exemption applies may apply in writing at any time seeking the removal of the restriction or a reduction in its scope.

The applicant may be requested in writing, within 60 days of making the application for removal of a restriction or a reduction in its scope, to provide additional information relating to the application.

If the Minister is satisfied that retention of the restriction or the refusal to grant a reduction in its scope would cause physical or financial hardship to patients in the area, the restriction must be removed or reduced in scope and the applicant must be notified in writing accordingly.

DIC.1.6 Refusal of Application

The Minister may refuse an application for a remote area exemption, the removal of a restriction on a remote area exemption, or a reduction in the scope of a restriction on a remote area exemption by giving the applicant written notice of the refusal and the reasons for the refusal.

DIC.1.7 Deemed Refusal for Review Purposes

For the purposes of review by the Administrative Appeals Tribunal, the Minister will be deemed to have refused an application for a remote area exemption, the removal of a remote area restriction or a reduction in the scope of such a restriction if, at the end of 60 days after the application was made, the Minister has not made a decision, or has not sought further information from the applicant, or, having obtained additional information from the applicant, has not notified the applicant of his or her decision.

DIC.1.8 Duration of Remote Area Exemption

A remote area exemption remains in force for 3 years unless revoked by the Minister.

DIC.1.9 Renewal of Exemption

A holder of a remote area exemption may apply for its renewal at any time within six months before it is due to expire. In any event, the Health Insurance Commission will send the holder a reminder notice and a renewal application six weeks before the current exemption expires.

The arrangements for dealing with renewal applications are the same as those applying to initial applications.

DIC.1.10 Revocation of Exemption

The Minister may revoke a remote area exemption if satisfied that the practice of the practitioner granted the exemption is no longer situated in a remote area, or that adequate diagnostic imaging facilities have become available in the relevant area to enable the written request requirement to

operate without causing physical or financial hardship to patients in that area.

The Minister may also revoke an exemption if a Medicare Participation Review Committee has so advised.

Before revoking a remote area exemption, the practitioner must be given written notice indicating that revocation is being considered, detailing the grounds for considering revocation, and stating that the practitioner has the right to make a written submission, within six months of being given the notice, as to why the exemption should not be revoked.

The Minister must give due consideration to any such submissions made by or on behalf of the practitioner during those six months.

DID REVIEW OF DECISIONS

DID.1 Administrative Appeals Tribunal

DID.1.1 Review by Administrative Appeals Tribunal

A practitioner may apply to the Administrative Appeals Tribunal for a review of:

(a) a decision to restrict a remote area exemption to certain "R-type" diagnostic imaging services; or
(b) a decision to reduce the scope of a remote area exemption;or
(c) a decision to refuse a remote area exemption; or
(d) a deemed refusal of a remote area exemption application or of the reduction of the scope of an exemption; or
(e) a decision to revoke a remote area exemption following advice by a Medicare Participation Review Committee.

DID.1.2 Statements to Accompany Notification of Decisions

When a person affected by a decision set out in DID.1.1 above is given written notice of that decision, the notice must include a statement advising that, if the person is dissatisfied with the decision, an application may be made to the Administrative Appeals Tribunal for a review of that decision.

Failure to comply with the above requirement does not affect the validity of the decision.

DIE PROHIBITED PRACTICES

DIE.1 Prohibited Diagnostic Imaging Practices

For Medicare benefits purposes, a person is taken to be engaged in a prohibited diagnostic practice if:

(a) the person is a service provider who directly or indirectly offers any inducement (whether by way of money, property or other benefit or advantage),or threatens any detriment or disadvantage, to a practitioner or any other person in order to encourage the practitioner to request the rendering of a diagnostic imaging service; or

(b) the person is a service provider who, without reasonable excuse:
  (i) directly or indirectly invites a practitioner to request the rendering of a diagnostic imaging service; or

(ii) does any act or thing that the person knows, or ought reasonably to know, is likely to have the effect of directly or indirectly encouraging a practitioner to request the rendering of a diagnostic imaging service; or

(c) the person is a practitioner, or the employer of a practitioner, who, without reasonable excuse, asks, receives or obtains, or agrees to receive or obtain, any property, benefit or advantage of any kind for himself or herself, or any other person, from a service provider or a person acting on behalf of the service provider; or

(d) the person is a practitioner who:
  (i) accepts a request from another practitioner to render a diagnostic imaging service; and
  (ii) in respect of any service (including a service for the use of diagnostic imaging equipment) connected with the rendering of the diagnostic imaging service, makes a payment, directly or indirectly:
    (A) to the other practitioner; or
    (B) if the diagnostic imaging service is not provided in a hospital - to a person who is the other practitioner's employer or to an employee of such a person; or

(e) the person is a practitioner who accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:
  (i) the two practitioners share, directly or indirectly, the cost of employing staff, or of buying, renting or maintaining items of equipment; and
  (ii) the amounts payable under the arrangement are not fixed at normal commercial rates; or

(f) the person is a practitioner who accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:
  (i) the 2 practitioners share a particular space in a building; or
  (ii) one practitioner provides, directly or indirectly, space in a building for the use or occupation of the other practitioner or permits the other practitioner to use or occupy space in a building;

  and the amounts payable under the arrangement are not fixed at normal commercial rates; or

(g) the person is a specialist in the speciality of diagnostic radiology who stations diagnostic imaging equipment or employees of the specialist at the premises of another practitioner (whether it is a full-time arrangement or not), so that diagnostic imaging services may be rendered to the practitioner's patients by or on behalf of the specialist.

DIF POSSIBLE PROHIBITED PRACTICES

DIF.1 Notice of Possible Breaches

DIF.1.1 Minister to Give Notice

Where the Minister has reasonable grounds for believing that a person has engaged in prohibited diagnostic imaging practices, the Minister is required to notify that person in writing giving the grounds for that belief and setting out the particulars of the prohibited practice. The Minister is also required to invite the practitioner to show cause within 28 days, commencing on the day the

notice is given, why no further action should be taken in relation to the person.

DIF.1.2 Minister to Consider Submissions

Where a person makes a submission to the Minister within 28 days, the Minister must take the submission into account in determining whether to take further action in respect of that person.

DIF.1.3 Minister May Take Further Action

If after 28 days the person has not made submissions to the Minister, or the person has made submissions and the Minister is satisfied that there are reasonable grounds for believing the person may have engaged in a prohibited diagnostic imaging practice, the Minister must give notice in writing to the Chairperson of a Medicare Participation Review Committee, setting out the particulars of the prohibited diagnostic imaging practice and the grounds for the Minister's belief.

Where a person provides a submission within the 28 day period and the Minister decides that no further action be taken against the person, that decision must be conveyed to the person in writing.

DIG MEDICARE PARTICIPATION REVIEW COMMITTEE

DIG.1 Chairperson to Establish Committee

DIG.1.1 Establishment of Committee

Upon receiving a notice from the Minister that a person is believed to have engaged in a prohibited diagnostic imaging practice, the Chairperson of a Medicare Participation Review Committee must establish a Committee.

Where a Chairperson receives a notice in relation to a practitioner, and the Committee has already been established in relation to the practitioner but the Committee has yet to make a determination in relation to the practitioner, the Chairperson must as soon as practicable, bring the notice to the attention of the Committee.

DIG.1.2 Composition of Committees

For the purposes of determining whether a person has engaged in a prohibited diagnostic imaging practice, the Medicare Participation Review Committee will consist of five persons.

With the exception of the Chairperson, who must be a legal practitioner of not less than five years standing, all members must be medical practitioners experienced in the rendering of diagnostic services.

No Committee member may have a direct or indirect interest (whether pecuniary or otherwise) in a matter to be considered by the Committee.

DIG.1.3 Provision of Information to Person

Any information given to a Committee by the Health Insurance Commission about a person must also be given to that person at or about the same time.

DIG.1.4 Committee may add Parties to Proceedings

Where a Committee has reasonable grounds to believe that a person who employs or employed the practitioner (in respect of whom the Committee was established), or is or was an officer of a body corporate that employs or employed that practitioner may have caused or permitted the practitioner, or any other person, to engage in prohibited diagnostic imaging practices, it may

determine whether the person caused or permitted those prohibited practices.

If the Committee has been established in relation to a body corporate which employs or employed a practitioner and the Committee has reasonable grounds to believe that a person who is or was an officer of the body corporate caused or permitted the practitioner to engage in a prohibited practice, it may determine whether it should consider whether that officer caused or permitted that prohibited practice to be engaged in.

DIG.1.5 Written Notice to Persons

Written notice of any determination made by a Medicare Participation Review Committee must be given to the person in respect or whom the determination is made.

DIG.1.6 Committee Determinations

If a Committee determines that a person engaged in, or permitted another person to engage in, a prohibited diagnostic imaging practice, it must make one of the following determinations:

- that no action should be taken against the person;
- that it should counsel the person;
- that it should reprimand the person;
- that the person, if a practitioner, is disqualified for the purposes of attracting Medicare benefits for some or all diagnostic imaging services for a specified period of not more than 5 years;
- where the person employs, or has employed, a practitioner - that any practitioner who is employed by the person is, while so employed, taken to be disqualified;
- where the person is or has been an officer of a body corporate that employs, or has employed, a practitioner - that any practitioner who is employed by a body corporate of which the person is an officer is, while so employed at a time when the person is such an officer, taken to be disqualified.

All determinations by Medicare Participation Review Committees must be in writing.

DIG.1.7 Nature of Disqualification

A Committee, having determined that a practitioner is disqualified or taken to be disqualified, must specify whether the disqualification is full or partial. If partial, the Committee must indicate whether the disqualification is in respect of one or more of the following:

- the provision of specified professional services, or the provision of professional services other than specified professional services;
- the provision of professional services to a specified class of persons, or the provision of professional services to persons other than a specified class of persons; and
- the provision of professional services within a specified location, or the provision of professional services otherwise than within a specified location.

DIG.1.8 Specification of Period of Disqualification

Where a Committee determines that a practitioner is disqualified, or taken to be disqualified, the Committee must specify in the determination the period of disqualification which must not exceed 5 years.

DIG.1.9 Determination of Services

A Committee must identify all services it determines were rendered as the result of a person engaging in prohibited diagnostic imaging practices. If Medicare benefits were paid to a practitioner or have been paid or are payable to a person other than a practitioner, the Committee

must determine that the benefits or a specified part of the benefits be paid by the practitioner to the Commonwealth. If Medicare benefits are payable but have not been paid, the Committee must determine that the benefits or a specified proportion of the benefits cease to be payable.

DIG.1.10 Revocation of Remote Area Exemption

If a Committee determines that a medical practitioner engaged in, or caused or permitted another person to engage in, a prohibited diagnostic imaging practice, and the practitioner has been granted a remote area exemption, the Committee must include in its determination advice to the Minister on whether the remote area exemption should be revoked and give its reasons for so advising.

DIG.1.11 Recovery of Benefits Paid

Any Medicare payment made for a diagnostic imaging service which contravened a State or Territory law relating to the use of diagnostic imaging procedures or equipment is payable to the Commonwealth by the person who contravened the law.

EXPLANATORY NOTES

DIH ULTRASOUND

DIH.1 Ultrasonic Cross-sectional Echography (items 791 and 793)

DIH.1.1 Item 791 covers ultrasonic cross-sectional echography where the examination is rendered by a practitioner on his/her own or partner's patient. Item 793 covers the examination where the patient has been referred to a medical practitioner outside the referring practitioner's practice especially for ultrasound scanning.

DIH.1.2 As a rule, benefit is payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved. Additional benefits may, however, be payable where examinations of non-contiguous body areas are involved. Such cases should be referred to the Health Insurance Commission.

DIH.2 Routine Ultrasonic Scanning

DIH.2.1 Medicare benefits are not attracted for routine ultrasonic screening associated with the termination of pregnancy.

DIH.2.2 Details of diagnostic imaging requesting requirement are set out in Section DIA.

DIH.3 Investigations of Vascular Disease (Items 990-999)

DIH.3.1 These items relate to examinations performed in the investigation of vascular disease. The fees include components for interpretation of the results and provision of the report which must be performed by a medical practitioner.

DII COMPUTERISED TOMOGRAPHY

DII.1 GENERAL

DII.1.1 It will be noted that there are separate items in respect of computerised tomography services, i.e. services performed on a body scanner and those performed on a brain scanner.

DII.2 Scan of more than one area

DII.2.1 Items have been provided to cover the common combinations of regions - see DIH.6. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, Item 2400 (scan of brain) and Item 2430 (scan of extremities), both examinations would attract separate benefit.

DII.3 CT Scan of Temporal Bones with Air Study - (Item 2406)

DII.3.1 This service would be preceded by a CT brain scan on either the same day or the previous day. The brain scan attracts a separate benefit.

DII.4 CT Scan of Spine with Intrathecal Contrast Medium - (Item 2419)

DII.4.1 The intrathecal injection of contrast medium attracts benefit under Item 2847 or 2848.

DII.5 CT Scan of Extremities - (Items 2429-2437)

DII.5.1 Benefit for these services is attracted according to the total number of slices irrespective of whether one part or more than one part of the one extremity is scanned or more than one extremity is scanned, eg, even if the left ankle and the right elbow are examined on the one occasion, the number of slices involved would determine the appropriate item.

DII.6 CT Scans of Multiple Regions - (Items 2438-2452)

DII.6.1 The Schedule provides items to cater for the common combinations of regions. The items relating to the individual regions should not be used when scans of multiple regions are performed.

DIJ DIAGNOSTIC RADIOLOGY

DIJ.1 General

DIJ.1.1 The benefits allocated to each item from 2502 to 2859 inclusive covers the total procedure, i.e. the examination, reading and report. Separate benefits are not payable for individual components of the service eg preliminary reading.

DIJ.2 Films - exposure of more than one

DIJ.2.1 Where the radiographic examination of a specific area involves the exposure of more than one film, benefits are payable once only, except where special provision is made in the description of the item for the inclusion of all films taken for the purpose of the examination.

DIJ.3 Comparison X-rays - Limbs

DIJ.3.1 Where it is necessary for one or more films of the opposite limb to be taken for comparison purposes, benefits are payable for radiographic examination of one limb only. Comparison views are considered to be part of the examination requested.

DIJ.4 Plain Abdominal Film (Items 2699/2703)

DIJ.4.1 Benefits are not attracted for Items 2699/2703 in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Benefits are payable for the preliminary plain film in conjunction with barium enema studies.

DIJ.5 Radiography of the Breast (Items 2734 and 2736)

DIJ.5.1 Benefits under these items are attracted only where the patient has been referred in specific circumstances. To facilitate these requirements the Regulations to the Health Insurance Act require the referring medical practitioner to complete a Letter/Notice of Referral (to be personally signed by the medical practitioner) indicating that the patient has been referred for mammography in accordance with the requirements outlined in the description of the items.

DIK MAGNETIC RESONANCE IMAGING

DIK.1 General

DIK.1.1 Benefits under this item are restricted to services rendered in specific recognised hospitals. The hospitals where benefits are attracted are:

- Royal North Shore Hospital of Sydney
  Pacific Highway
  ST LEONARDS NSW 2065

- Alfred Hospital
  Commercial Road
  PRAHRAN VIC 3181

- Royal Melbourne Hospital
  Grattan Street
  PARKVILLE VIC 3052

- St Vincent's Hospital
  Victoria Parade
  FITZROY VIC 3065

- Princess Alexandra Hospital
  Ipswich Road
  WOOLLOONGABBA QLD 4102

- Royal Adelaide Hospital
  North Terrace
  ADELAIDE SA 5000

- Sir Charles Gairdner Hospital
  Verdun Street
  NEDLANDS WA 6009

DIL NUCLEAR MEDICINE IMAGING

DIL.1 General

DIL.1.1 There is a differential fee structure for items covering nuclear medicine depending on whether or not the service is performed at a computerised installation.

DIL.1.2 The "C" Schedule fee applies only where the service covered by the item is performed in a nuclear medicine installation with computerised processing facilities.

DIL.1.3 The "NC" Schedule fee applies where the service covered by the item is performed in a nuclear medicine installation without computerised processing facilities.

DIL.1.4 It is not required that the computer be actually used in the performance of a particular scan in order that the service will attract the fee and benefit appropriate for a computerised installation.

DIL.1.5 Many items for nuclear medicine imaging contain more than one service. If two or more services within the one item are rendered, full benefits are attracted for each service.

DIL.1.6 Benefits for a nuclear scanning service cover the preliminary examination of the patient, estimation of dosage, supervision of the administration of the dose and the performance of the scan, and compilation of the final report. Additional benefits will only be attracted for specialist physician or consultant physician attendances under Part 1 of the Schedule where there is a request for a full medical examination accompanied by a Letter/Notice of Referral.

DIL.2 Radiopharmaceuticals

DIL.2.1 The Schedule fees for nuclear medicine investigations incorporate the costs of radiopharmaceuticals.

DIL.3 Study of region or organ not covered by any other item in this part (items 8873/74)

DIL.3.1 A nominal fee only has been allocated to these items. The procedure to be adopted for the purpose of facilitating payment of Medicare benefits is outlined at paragraph L.1 et seq. of the 1 May 1990 Medicare Benefits Schedule Book.

	PART 6 - MISCELLANEOUS PROCEDURES
	DIVISION 2
791	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, not associated with Item 793, 794 or 913 where the patient is not referred by a medical practitioner for ultrasonic examination - each ultrasonic examination not exceeding two examinations in any one pregnancy (NR) *(See para 6.2 of explanatory notes to this Part)* **Fee:** $32.00 **Benefit:** 75% $24.00: 85%/$26 $27.20
793	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not associated with Item 791, 794 or 913 and where the referring medical practitioner is not a member of a group of practitioners of which the first-mentioned practitioner is a member (R) *(See para 6.2 of explanatory notes to this Part)* **Fee:** $93.00 **Benefit:** 75% $69.75: 85%/$26 $79.05
794	ULTRASONIC ECHOGRAPHY, UNIDIMENSIONAL, not associated with Item 791, 793 or 913 (NR) **Fee:** $56.00 **Benefit:** 75% $42.00: 85%/$26 $47.60
	DIVISION 8
913	ECHOCARDIOGRAPHY, not covered by Item 791 or 793 (R) **Fee:** $80.00 **Benefit:** 75% $60.00: 85%/$26 $68.00
	DIVISION 9
990	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis of carotid vessels (with or without vertebral arteries), peripheral vessels or intra-thoracic or intra-abdominal vascular structures (excluding cardiac and pregnancy related studies), (not associated with Item 793) - one examination and report (R) *(See para 6.4 of explanatory notes to this Part)* **Fee:** $160.00 **Benefit:** 75% $120.00: 85%/$26 $136.00
991	- two or more examinations of the kind referred to in Item 990 and report (not associated with Item 793) (R) *(See para 6.4 of explanatory notes to this Part)* **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
992	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis of carotid vessels, with oculoplethysmography (not associated with Item 793) - examination and report (R) *(See para 6.4 of explanatory notes to this Part)* **Fee:** $192.00 **Benefit:** 75% $144.00: 85%/$26 $166.00

Item	Description
993	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis, of peripheral vessels and carotid vessels, with oculoplethysmography (not associated with Item 793) - examination and report (R) *(See para 6.4 of explanatory notes to this Part)* **Fee:** $310.00 **Benefit:** 75% $232.50: 85%/$26 $284.00
995	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis, of peripheral vessels, including any of the investigations covered by Item 795, 796 or 797 (not associated with Item 793) - examination and report (R) *(See para 6.4 of explanatory notes to this Part)* **Fee:** $186.00 **Benefit:** 75% $139.50: 85%/$26 $160.00
999	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis, of peripheral vessels, including any of the investigations covered by Item 798 (not associated with Item 793) - examination and report (R) *(See para 6.4 of explanatory notes to this Part)* **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00

PART 7A - COMPUTERISED TOMOGRAPHY (EXCLUDING MAGNETIC RESONANCE IMAGING)

DIVISION 1 - COMPUTERISED TOMOGRAPHY ON A BODY SCANNER

COMPUTERISED TOMOGRAPHY ON A BODY SCANNER

Item	Description
2400	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with or without scan of internal auditory meatus without intravenous contrast medium (not covered by Item 2447 or 2450) (R) **Fee:** $138.00 **Benefit:** 75% $103.50: 85%/$26 $117.30
2401	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with or without scan of internal auditory meatus with intravenous contrast medium (not covered by Item 2448 or 2451) (R) **Fee:** $192.00 **Benefit:** 75% $144.00: 85%/$26 $166.00
2402	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with or without scan of internal auditory meatus without intravenous contrast medium (minimum of 8 slices) and with intravenous contrast medium (not covered by Item 2449 or 2452) (R) **Fee:** $225.00 **Benefit:** 75% $168.75: 85%/$26 $199.00
2403	COMPUTERISED TOMOGRAPHY - SCAN OF PITUITARY FOSSA by multiple thin slices (including reconstructions) without or with intravenous contrast medium and with or without brain scan (R) **Fee:** $460.00 **Benefit:** 75% $345.00: 85%/$26 $434.00
2404	COMPUTERISED TOMOGRAPHY - SCAN OF ORBITS by multiple thin slices (including reconstructions) without or with intravenous contrast medium and with or without brain scan (R) **Fee:** $455.00 **Benefit:** 75% $341.25: 85%/$26 $429.00
2405	COMPUTERISED TOMOGRAPHY - SCAN OF MIDDLE EAR AND TEMPORAL BONE, unilateral or bilateral, detailed study by multiplethin slices (including reconstructions) without or within travenous contrast medium and with or without brain scan (R) **Fee:** $445.00 **Benefit:** 75% $333.75: 85%/$26 $419.00
2406	COMPUTERISED TOMOGRAPHY - SCAN OF TEMPORAL BONES WITH AIRSTUDY (including reconstructions) and including intrathecal injection, not including an associated brain scan (R) *(See para 7A.3 of explanatory notes to this Part)* **Fee:** $355.00 **Benefit:** 75% $266.25: 85%/$26 $329.00
2407	COMPUTERISED TOMOGRAPHY - SCAN OF FACIAL BONES, sinuses and salivary glands - scan of one or more regions without intravenous contrast medium (R) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00

Item	Description
2408	COMPUTERISED TOMOGRAPHY - SCAN OF FACIAL BONES, sinuses and salivary glands - scan of one or more regions with intravenous contrast medium (R) **Fee:** $265.00 **Benefit:** 75% $198.75: 85%/$26 $239.00
2409	COMPUTERISED TOMOGRAPHY - SCAN OF FACIAL BONES, sinuses and salivary glands - scan of one or more regions without and with intravenous contrast medium (R) **Fee:** $375.00 **Benefit:** 75% $281.25: 85%/$26 $349.00
2410	COMPUTERISED TOMOGRAPHY - SCAN OF SOFT TISSUES OF NECK, including larynx, pharynx and upper oesophagus (not associated with cervical spine) - scan of one or more regions without intravenous contrast medium (not covered by Item 2444) (R) **Fee:** $355.00 **Benefit:** 75% $266.25: 85%/$26 $329.00
2411	COMPUTERISED TOMOGRAPHY - SCAN OF SOFT TISSUES OF NECK, including larynx, pharynx and upper oesophagus (notassociated with cervical spine) - scan of one or more regions with intravenous contrast medium (not covered by Item 2445) (R) **Fee:** $385.00 **Benefit:** 75% $288.75: 85%/$26 $359.00
2412	COMPUTERISED TOMOGRAPHY - SCAN OF SOFT TISSUES OF NECK, including larynx, pharynx and upper oesophagus (not associated with cervical spine) - scan of one or more regions without and with intravenous contrast medium (not covered by Item 2446) (R) **Fee:** $420.00 **Benefit:** 75% $315.00: 85%/$26 $394.00
2413	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions - 25 slices or less without intravenous contrast medium (R) **Fee:** $176.00 **Benefit:** 75% $132.00: 85%/$26 $150.00
2414	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions - 25 slices or less with intravenous contrast medium (R) **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00
2415	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions - 25 slices or less without and with intravenous contrast medium (R) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
2416	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions - 26 or more slices without intravenous contrast medium (R) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
2417	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions - 26 or more slices with intravenous contrast medium (R) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
2418	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions - 26 or more slices without and with intravenous contrast medium (R) **Fee:** $385.00 **Benefit:** 75% $288.75: 85%/$26 $359.00

Item	Description
2419	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, one or more regions with intrathecal contrast medium (not including the preparation by intrathecal injection of contrast medium) (R) *(See para 7A.4 of explanatory notes to this Part)* **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
2420	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST (including lungs, mediastinum and pleura) without intravenous contrast medium (not covered by Item 2438, 2441, 2444, 2447 or 2450) (R) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
2421	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST (including lungs,mediastinum and pleura) with intravenous contrast medium (not covered by Item 2439, 2442, 2445, 2448 or 2451) (R) **Fee:** $285.00 **Benefit:** 75% $213.75: 85%/$26 $259.00
2422	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST (including lungs, mediastinum and pleura) without intravenous contrast medium (minimum of 8 slices) and with intravenous contrast medium (not covered by Item 2440, 2443, 2446, 2449 or 2452) (R) **Fee:** $360.00 **Benefit:** 75% $270.00: 85%/$26 $334.00
2423	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN (diaphragm to iliac crest) or PELVIS without intravenous contrast medium (not covered by Item 2438, 2441, 2444 or 2450) (R) **Fee:** $138.00 **Benefit:** 75% $103.50: 85%/$26 $117.30
2424	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN (diaphragm to iliac crest) or PELVIS with intravenous contrast medium (not covered by Item 2439, 2442, 2445 or 2451) (R) **Fee:** $168.00 **Benefit:** 75% $126.00: 85%/$26 $142.80
2425	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN (diaphragm to iliac crest) or PELVIS without intravenous contrast medium (minimum of 8 slices) and with intravenous contrast medium (not covered by Item 2440, 2443, 2446 or 2452) (R) **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
2426	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN AND PELVIS without intravenous contrast medium (not covered by Item 2438, 2441, 2444 or 2450) (R) **Fee:** $210.00 **Benefit:** 75% $157.50: 85%/$26 $184.00
2427	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN AND PELVIS with intravenous contrast medium (not covered by Item 2439, 2442, 2445 or 2451) (R) **Fee:** $255.00 **Benefit:** 75% $191.25: 85%/$26 $229.00
2428	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN AND PELVIS without intravenous contrast medium (minimum of 8 slices) and with intravenous contrast medium (not covered by Item 2440, 2443, 2446 or 2452) (R) **Fee:** $360.00 **Benefit:** 75% $270.00: 85%/$26 $334.00

Item	Description
2429	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving up to 20 slices without intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $138.00 **Benefit:** 75% $103.50: 85%/$26 $117.30
2430	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving up to 20 slices with intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $168.00 **Benefit:** 75% $126.00: 85%/$26 $142.80
2431	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving up to 20 slices without and with intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00
2432	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving more than 20 slices but not more than 40 slices without intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $176.00 **Benefit:** 75% $132.00: 85%/$26 $150.00
2433	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving more than 20 slices but not more than 40 slices with intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $205.00 **Benefit:** 75% $153.75: 85%/$26 $179.00
2434	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving more than 20 slices but not more than 40 slices without and with intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
2435	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving more than 40 slices without intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
2436	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving more than 40 slices with intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
2437	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, ONE OR MORE REGIONS involving more than 40 slices without and with intravenous contrast medium (R) *(See para 7A.5 of explanatory notes to this Part)* **Fee:** $350.00 **Benefit:** 75% $262.50: 85%/$26 $324.00

Item	Description
2438	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) without intravenous contrast medium (not covered by Item 2441, 2444 or 2450) (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
2439	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) with intravenous contrast medium (not covered by Item 2442, 2445 or 2451) (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $290.00 **Benefit:** 75% $217.50: 85%/$26 $264.00
2440	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) without and with intravenous contrast medium (not covered by Item 2443, 2446 or 2452) (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $365.00 **Benefit:** 75% $273.75: 85%/$26 $339.00
2441	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, ABDOMEN AND PELVIS without intravenous contrast medium (not covered by Item 2444) (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $325.00 **Benefit:** 75% $243.75: 85%/$26 $299.00
2442	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, ABDOMEN AND PELVIS with intravenous contrast medium (not covered by Item 2445) (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $365.00 **Benefit:** 75% $273.75: 85%/$26 $339.00
2443	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, ABDOMEN AND PELVIS without and with intravenous contrast medium (not covered by Item 2446) (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $510.00 **Benefit:** 75% $382.50: 85%/$26 $484.00
2444	COMPUTERISED TOMOGRAPHY - SCAN OF NECK, CHEST, ABDOMEN AND PELVIS without intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $465.00 **Benefit:** 75% $348.75: 85%/$26 $439.00
2445	COMPUTERISED TOMOGRAPHY - SCAN OF NECK, CHEST, ABDOMEN AND PELVIS with intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $510.00 **Benefit:** 75% $382.50: 85%/$26 $484.00
2446	COMPUTERISED TOMOGRAPHY - SCAN OF NECK, CHEST, ABDOMEN AND PELVIS without and with intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $615.00 **Benefit:** 75% $461.25: 85%/$26 $589.00

Item	Description
2447	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN AND CHEST without intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
2448	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN AND CHEST with intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $290.00 **Benefit:** 75% $217.50: 85%/$26 $264.00
2449	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN AND CHESTwithout and with intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $400.00 **Benefit:** 75% $300.00: 85%/$26 $374.00
2450	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) and SCAN OF BRAIN without intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $355.00 **Benefit:** 75% $266.25: 85%/$26 $329.00
2451	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) and SCAN OF BRAIN with intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $400.00 **Benefit:** 75% $300.00: 85%/$26 $374.00
2452	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) and SCAN OF BRAIN without and with intravenous contrast medium (R) *(See para 7A.6 of explanatory notes to this Part)* **Fee:** $510.00 **Benefit:** 75% $382.50: 85%/$26 $484.00
2453	COMPUTERISED TOMOGRAPHY - PELVIMETRY (R) **Fee:** $138.00 **Benefit:** 75% $103.50: 85%/$26 $117.30
2454	COMPUTERISED TOMOGRAPHY - DYNAMIC SCAN OF REGION not associated with any other item in this Part (R) **Fee:** $168.00 **Benefit:** 75% $126.00: 85%/$26 $142.80
2455	COMPUTERISED TOMOGRAPHY - DYNAMIC SCAN OF REGION when associated with another item in this Part (R) **Derived Fee:** The fee for computerised tomography of the area and report plus an amount of $108.00

DIVISION 2 - COMPUTERISED TOMOGRAPHY ON A BRAIN SCANNER

COMPUTERISED TOMOGRAPHY ON A BRAIN SCANNER

Item	Description
2458	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN without intravenous contrast medium (R) **Fee:** $70.00 **Benefit:** 75% $52.50: 85%/$26 $59.50
2459	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with intravenous contrast medium (R) **Fee:** $85.00 **Benefit:** 75% $63.75: 85%/$26 $72.25
2460	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN without and with intravenous contrast medium (R) **Fee:** $132.00 **Benefit:** 75% $99.00: 85%/$26 $112.20

PART 8 - DIAGNOSTIC RADIOLOGY

DIVISION 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES AND REPORT (WITH OR WITHOUT FLUOROSCOPY)

Item	Description / Fee	Benefit	75% : 85%/$26	85%/$26
	DIGITS OR PHALANGES - all or any of either hand or either foot 2502(NR) - 2505(R)			
2502	Fee: $29.00	Benefit: 75%	$21.75: 85%/$26	$24.65
2505	Fee: $38.50	Benefit: 75%	$28.90: 85%/$26	$32.75
	HAND, WRIST, FOREARM, ELBOW OR ARM (elbow to shoulder) 2508(NR) - 2512(R)			
2508	Fee: $29.00	Benefit: 75%	$21.75: 85%/$26	$24.65
2512	Fee: $38.50	Benefit: 75%	$28.90: 85%/$26	$32.75
	HAND, WRIST AND LOWER FOREARM; UPPER FOREARM AND ELBOW; OR ELBOW AND ARM (elbow to shoulder) 2516(NR) - 2520(R)			
2516	Fee: $39.50	Benefit: 75%	$29.65: 85%/$26	$33.60
2520	Fee: $52.00	Benefit: 75%	$39.00: 85%/$26	$44.20
	FOOT, ANKLE, LOWER LEG, UPPER LEG, KNEE OR THIGH (femur) 2524(NR) - 2528(R)			
2524	Fee: $31.50	Benefit: 75%	$23.65: 85%/$26	$26.80
2528	Fee: $42.00	Benefit: 75%	$31.50: 85%/$26	$35.70
	FOOT, ANKLE AND LOWER LEG; OR UPPER LEG AND KNEE 2532(NR) - 2537(R)			
2532	Fee: $48.00	Benefit: 75%	$36.00: 85%/$26	$40.80
2537	Fee: $64.00	Benefit: 75%	$48.00: 85%/$26	$54.40

DIVISION 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR HIP JOINT AND REPORT

Item	Description / Fee	Benefit	75% : 85%/$26	85%/$26
	SHOULDER OR SCAPULA 2539(NR) - 2541(R)			
2539	Fee: $39.50	Benefit: 75%	$29.65: 85%/$26	$33.60
2541	Fee: $52.00	Benefit: 75%	$39.00: 85%/$26	$44.20
	CLAVICLE 2543(NR) - 2545(R)			
2543	Fee: $31.50	Benefit: 75%	$23.65: 85%/$26	$26.80
2545	Fee: $42.00	Benefit: 75%	$31.50: 85%/$26	$35.70
	HIP JOINT (R)			
2548	Fee: $46.00	Benefit: 75%	$34.50: 85%/$26	$39.10
	PELVIC GIRDLE (R)			
2551	Fee: $59.00	Benefit: 75%	$44.25: 85%/$26	$50.15
	SACRO-ILIAC JOINTS (R)			
2554	Fee: $59.00	Benefit: 75%	$44.25: 85%/$26	$50.15

Item	Description
2557	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60

DIVISION 3 - RADIOGRAPHIC EXAMINATION OF HEAD AND REPORT

Item	Description
2560	SKULL (calvarium) (R) **Fee:** $63.00 **Benefit:** 75% $47.25: 85%/$26 $53.55
2563	SINUSES (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2566	MASTOIDS (R) **Fee:** $63.00 **Benefit:** 75% $47.25: 85%/$26 $53.55
2569	PETROUS TEMPORAL BONES (R) **Fee:** $63.00 **Benefit:** 75% $47.25: 85%/$26 $53.55
2573	FACIAL BONES - orbit, maxilla or malar, any or all (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2576	MANDIBLE (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2579	SALIVARY CALCULUS (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2581	NOSE (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2583	EYE (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2585	TEMPORO-MANDIBULAR JOINTS (R) **Fee:** $48.00 **Benefit:** 75% $36.00: 85%/$26 $40.80
2587	TEETH - SINGLE AREA (R) **Fee:** $32.00 **Benefit:** 75% $24.00: 85%/$26 $27.20
2589	TEETH - FULL MOUTH (R) **Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60
2590	TEETH, ORTHOPANTOMOGRAPHY (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2591	PALATO-PHARYNGEAL STUDIES with fluoroscopic screening (R) **Fee:** $63.00 **Benefit:** 75% $47.25: 85%/$26 $53.55
2593	PALATO-PHARYNGEAL STUDIES without fluoroscopic screening (R) **Fee:** $48.00 **Benefit:** 75% $36.00: 85%/$26 $40.80

Item	Description	Fee	Benefit: 75%	85%/$26
2595	LARYNX (R)	$42.00	$31.50	$35.70
	DIVISION 4 - RADIOGRAPHIC EXAMINATION OF SPINE AND REPORT			
2597	SPINE - CERVICAL (R)	$63.00	$47.25	$53.55
2599	SPINE - THORACIC (R)	$54.00	$40.50	$45.90
2601	SPINE - LUMBO-SACRAL (R)	$74.00	$55.50	$62.90
2604	SPINE - SACRO-COCCYGEAL (R)	$45.00	$33.75	$38.25
2607	SPINE - TWO REGIONS (R)	$93.00	$69.75	$79.05
2609	SPINE - THREE OR MORE REGIONS (R)	$128.00	$96.00	$108.80
2611	SPINE - FUNCTIONAL VIEWS OF ONE AREA (R)	$20.00	$15.00	$17.00
	DIVISION 5 - BONE AGE STUDY AND SKELETAL SURVEYS			
2614	BONE AGE STUDY, WRIST AND KNEE (R)	$46.00	$34.50	$39.10
2617	BONE AGE STUDY, WRIST (R)	$38.50	$28.90	$32.75
2621	SKELETAL SURVEY INVOLVING FOUR OR MORE REGIONS (R)	$87.00	$65.25	$73.95
	DIVISION 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION AND REPORT			
2625	CHEST (lung fields) by direct radiography 2625(NR) - 2627(R)	$34.50	$25.90	$29.35
2627		$46.00	$34.50	$39.10
2630	CHEST (lung fields) by direct radiography WITH FLUOROSCOPIC SCREENING (R)	$59.00	$44.25	$50.15

Item	Description
2634	THORACIC INLET OR TRACHEA (R) **Fee:** $38.50 **Benefit:** 75% $28.90: 85%/$26 $32.75
2638	CHEST, BY MINIATURE RADIOGRAPHY (R) **Fee:** $21.00 **Benefit:** 75% $15.75: 85%/$26 $17.85
2642 2646	CARDIAC EXAMINATION (including barium swallow) 2642(NR) - 2646(R) **Fee:** $44.50 **Benefit:** 75% $33.40: 85%/$26 $37.85 **Fee:** $59.00 **Benefit:** 75% $44.25: 85%/$26 $50.15
2655	STERNUM OR RIBS ON ONE SIDE (R) **Fee:** $42.00 **Benefit:** 75% $31.50: 85%/$26 $35.70
2656	STERNUM AND RIBS ON ONE SIDE, OR RIBS ON BOTH SIDES (R) **Fee:** $55.00 **Benefit:** 75% $41.25: 85%/$26 $46.75
2657	STERNUM AND RIBS ON BOTH SIDES (R) **Fee:** $67.00 **Benefit:** 75% $50.25: 85%/$26 $56.95
	DIVISION 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT AND REPORT
2665	PLAIN RENAL ONLY (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2672	DRIP-INFUSION PYELOGRAPHY (R) **Fee:** $128.00 **Benefit:** 75% $96.00: 85%/$26 $108.80
2676	INTRAVENOUS PYELOGRAPHY, including preliminary plain film (R) **Fee:** $120.00 **Benefit:** 75% $90.00: 85%/$26 $102.00
2678	INTRAVENOUS PYELOGRAPHY, including preliminary plain film and limited (R) **Fee:** $150.00 **Benefit:** 75% $112.50: 85%/$26 $127.50
2681	INTRAVENOUS PYELOGRAPHY, including preliminary plain film with delayed examination for the CYSTO-URETERIC REFLEX (R) **Fee:** $152.00 **Benefit:** 75% $114.00: 85%/$26 $129.20
2687	ANTEGRADE OR RETROGRADE PYELOGRAPHY - including preliminary plain film (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60
2690	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY (R) **Fee:** $64.00 **Benefit:** 75% $48.00: 85%/$26 $54.40
2694	RETROGRADE MICTURATING CYSTO-URETHROGRAPHY (R) **Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60
2697	PETRO-PERITONEAL PNEUMOGRAM (R) **Fee:** $48.00 **Benefit:** 75% $36.00: 85%/$26 $40.80

DIVISION 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM (WITH OR WITHOUT FLUOROSCOPY) AND REPORT

Item	Description
	PLAIN ABDOMINAL ONLY, not associated with Item 2709, 2711, 2714 or 2720 2699(NR) - 2703(R) *(See para 8.4 of explanatory notes to this Part)*
2699	**Fee:** $34.50 **Benefit:** 75% $25.90: 85%/$26 $29.35
2703	**Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
	OESOPHAGUS, with or without examination for foreign body or barium swallow (R)
2706	**Fee:** $65.00 **Benefit:** 75% $48.75: 85%/$26 $55.25
	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH AND DUODENUM, with or without screening of chest, with or without preliminary plain film (R)
2709	**Fee:** $89.00 **Benefit:** 75% $66.75: 85%/$26 $75.65
	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)
2711	**Fee:** $106.00 **Benefit:** 75% $79.50: 85%/$26 $90.10
	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R)
2714	**Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60
	OPAQUE ENEMA (R)
2716	**Fee:** $89.00 **Benefit:** 75% $66.75: 85%/$26 $75.65
	OPAQUE ENEMA, including air contrast study (R)
2718	**Fee:** $106.00 **Benefit:** 75% $79.50: 85%/$26 $90.10
	GRAHAM'S TEST (cholecystography), including preliminary abdominal radiograph (R)
2720	**Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60
	CHOLEGRAPHY DIRECT - operative or post-operative (R)
2722	**Fee:** $74.00 **Benefit:** 75% $55.50: 85%/$26 $62.90
	CHOLEGRAPHY - intravenous (R)
2724	**Fee:** $106.00 **Benefit:** 75% $79.50: 85%/$26 $90.10
	CHOLEGRAPHY - percutaneous transhepatic (R)
2726	**Fee:** $87.00 **Benefit:** 75% $65.25: 85%/$26 $73.95
	CHOLEGRAPHY - drip infusion (R)
2728	**Fee:** $144.00 **Benefit:** 75% $108.00: 85%/$26 $122.40

	DIVISION 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES AND REPORT
2730	FOREIGN BODY IN EYE (special method, Sweet's or other) (R) **Fee:** $64.00 **Benefit:** 75% $48.00: 85%/$26 $54.40 19
2732	FOREIGN BODY, LOCALISATION OF AND REPORT, not covered by any other item in this Part (R) **Derived Fee:** The fee for the radiographic examination of the area and report plus an amount of $19.80 131
	DIVISION 10 - RADIOGRAPHIC EXAMINATION OF BREASTS AND REPORT
2734 S	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS (with or without thermography) AND REPORT where the patient is referred with a specific request for this procedure and there is reason to suspect the presence of malignancy in the breasts because of the past occurrence of breast malignancy in the patient or members of the patient's family or because symptoms or indications of malignancy were found on an examination of the patient by a medical practitioner (R) *(See para 8.5 of explanatory notes to this Part)* **Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60 22
2736 S	RADIOGRAPHIC EXAMINATION OF ONE BREAST (with or without thermography) AND REPORT where the patient is referred with a specific request for this procedure and there is reason to suspect the presence of malignancy in the breast because of the past occurrence of breast malignancy in the patient or members of the patient's family or because symptoms or indications of malignancy were found on an examination of the patient by a medical practitioner (R) *(See para 8.5 of explanatory notes to this Part)* **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10 6
	DIVISION 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY AND REPORT
2738	PREGNANT UTERUS (R) **Fee:** $47.00 **Benefit:** 75% $35.25: 85%/$26 $39.95 31
2740	PELVIMETRY OR PLACENTOGRAPHY (R) **Fee:** $87.00 **Benefit:** 75% $65.25: 85%/$26 $73.95 41
2742	CONTROL X-RAYS ASSOCIATED WITH INTRAUTERINE FOETAL BLOOD TRANSFUSION (R) **Fee:** $64.00 **Benefit:** 75% $48.00: 85%/$26 $54.40 1

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DIVISION 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA AND REPORT

Item	Description
2744	SERIAL ANGIOCARDIOGRAPHY (rapid cassette changing) - each series (AU 8 - 409/517) (R) **Fee:** $81.00 **Benefit:** 75% $60.75: 85%/$26 $68.85
2746	SERIAL ANGIOCARDIOGRAPHY (SINGLE PLAIN - direct roll-film method) - each series (AU 8 - 409/517) (R) **Fee:** $112.00 **Benefit:** 75% $84.00: 85%/$26 $95.20
2748	SERIAL ANGIOCARDIOGRAPHY (BI-PLANE - direct roll-film method) - each series (AU 8 - 409/517) (R) **Fee:** $112.00 **Benefit:** 75% $84.00: 85%/$26 $95.20
2750	SERIAL ANGIOCARDIOGRAPHY (indirect roll-film method) - each series (AU 8 - 409/517) (R) **Fee:** $112.00 **Benefit:** 75% $84.00: 85%/$26 $95.20
2751	SELECTIVE CORONARY ARTERIOGRAPHY (R) **Fee:** $295.00 **Benefit:** 75% $221.25: 85%/$26 $269.00
2752	DISCOGRAPHY - one disc (R) **Fee:** $67.00 **Benefit:** 75% $50.25: 85%/$26 $56.95
2754	DACRYOCYSTOGRAPHY - one side (R) **Fee:** $46.00 **Benefit:** 75% $34.50: 85%/$26 $39.10
2756	ENCEPHALOGRAPHY (R) **Fee:** $100.00 **Benefit:** 75% $75.00: 85%/$26 $85.00
2758	CEREBRAL ANGIOGRAPHY - one side (R) **Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60
2760	CEREBRAL VENTRICULOGRAPHY (R) **Fee:** $87.00 **Benefit:** 75% $65.25: 85%/$26 $73.95
2762	HYSTEROSALPINGOGRAPHY (R) **Fee:** $65.00 **Benefit:** 75% $48.75: 85%/$26 $55.25
2764	BRONCHOGRAPHY - one side (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60
2766	ARTERIOGRAPHY, PERIPHERAL - one side (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60
2768	PHLEBOGRAPHY - one side (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60

Item	Service
2770	AORTOGRAPHY (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60
2772	SPLENOGRAPHY (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60
2773	MYELOGRAPHY, one region (R) **Fee:** $116.00 **Benefit:** 75% $87.00: 85%/$26 $98.60
2774	MYELOGRAPHY, two regions (R) **Fee:** $192.00 **Benefit:** 75% $144.00: 85%/$26 $166.00
2775	MYELOGRAPHY, three regions (R) **Fee:** $260.00 **Benefit:** 75% $195.00: 85%/$26 $234.00
2776	SELECTIVE ARTERIOGRAPHY - per injection and film run (R) **Fee:** $96.00 **Benefit:** 75% $72.00: 85%/$26 $81.60
2778	SIALOGRAPHY - one gland (R) **Fee:** $65.00 **Benefit:** 75% $48.75: 85%/$26 $55.25
2780	VASOEPIDIDYMOGRAPHY - one side (R) **Fee:** $65.00 **Benefit:** 75% $48.75: 85%/$26 $55.25
2782	SINUSES AND FISTULAE (R) **Derived Fee:** The fee for the radiographic examination of the area and report plus an amount of $21.00
2784	LARYNGOGRAPHY with contrast media (R) **Fee:** $48.00 **Benefit:** 75% $36.00: 85%/$26 $40.80
2786	PNEUMOARTHROGRAPHY (R) **Fee:** $41.00 **Benefit:** 75% $30.75: 85%/$26 $34.85
2788	ARTHROGRAPHY - contrast (R) **Fee:** $48.00 **Benefit:** 75% $36.00: 85%/$26 $40.80
2790	ARTHROGRAPHY - double contrast (R) **Fee:** $84.00 **Benefit:** 75% $63.00: 85%/$26 $71.40
2792	LYMPHANGIOGRAPHY, including follow up radiography (R) **Fee:** $64.00 **Benefit:** 75% $48.00: 85%/$26 $54.40
2794	PNEUMOMEDIASTINUM (R) **Fee:** $59.00 **Benefit:** 75% $44.25: 85%/$26 $50.15
	DIVISION 13 - TOMOGRAPHY AND REPORT
2796	TOMOGRAPHY OF ANY PART AND REPORT (R) **Fee:** $59.00 **Benefit:** 75% $44.25: 85%/$26 $50.15

Item	Description
	DIVISION 14 - STEREOSCOPIC EXAMINATION AND REPORT
2798	STEREOSCOPIC EXAMINATION AND REPORT (R) **Derived Fee:** The fee for the radiographic examination of the area and report plus an amount of $12.60
	DIVISION 15 - FLUOROSCOPIC EXAMINATION AND REPORT
2800	EXAMINATION WITH GENERAL ANAESTHESIA (AU 7 - 408/514) (R) **Fee:** $42.00 **Benefit:** 75% $31.50: 85%/$26 $35.70
2802	EXAMINATION WITHOUT GENERAL ANAESTHESIA (R) **Fee:** $29.00 **Benefit:** 75% $21.75: 85%/$26 $24.65
	DIVISION 15A - EXAMINATION NOT OTHERWISE COVERED
2804	Radiographic examination of any part and report not covered by any item in this Part (R) **Fee:** $20.00 **Benefit:** 75% $15.00: 85%/$26 $17.00
	DIVISION 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE, BY INJECTION OR REMOVAL OF FLUID AND REPLACEMENT
2805	ENCEPHALOGRAPHY (AU 10 - 450/521) (NR) **Fee:** $176.00 **Benefit:** 75% $132.00: 85%/$26 $150.00
2807	CEREBRAL ANGIOGRAPHY (one side) - percutaneous, catheter or open exposure (AU 10 - 450/521) (NR) **Fee:** $124.00 **Benefit:** 75% $93.00: 85%/$26 $105.40
2811	CEREBRAL VENTRICULOGRAPHY (AU 10 - 450/521) (NR) **Fee:** $168.00 **Benefit:** 75% $126.00: 85%/$26 $142.80
2813	DACRYOCYSTOGRAPHY - one side (NR) **Fee:** $38.50 **Benefit:** 75% $28.90: 85%/$26 $32.75
2815	BRONCHOGRAPHY - one or both sides (AU 8 - 409/517) (NR) **Fee:** $59.00 **Benefit:** 75% $44.25: 85%/$26 $50.15
2817	AORTOGRAPHY (AU 8 - 409/517) (NR) **Fee:** $69.00 **Benefit:** 75% $51.75: 85%/$26 $58.65
2819	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY - one vessel (AU 6 - 407/513) (NR) **Fee:** $51.00 **Benefit:** 75% $38.25: 85%/$26 $43.35

Item	Description	Fee	Benefit: 75%	85%/$26	
2823	SPLENOGRAPHY (AU 6 - 407/513) (NR)	$42.00	$31.50	$35.70	—
2825	RETROPERITONEAL PNEUMOGRAM (NR)	$46.00	$34.50	$39.10	7
2827	SELECTIVE ARTERIOGRAM or PHLEBOGRAM (AU 6 - 407/513) (NR)	$42.00	$31.50	$35.70	14
2831	PERCUTANEOUS INJECTION of radio-opaque material into RENAL CYST (including aspiration) or RENAL PELVIS for antegrade pyelography (NR)	$59.00	$44.25	$50.15	88
2833	PNEUMOARTHROGRAPHY or PNEUMOPERITONEUM (NR)	$47.00	$35.25	$39.95	—
2834	ARTHROGRAPHY, single or double contrast, excluding arthrography of the joints between articular processes of the vertebrae (NR)	$47.00	$35.25	$39.95	6
2837	DRIP-INFUSION PYELOGRAPHY OR CHOLEGRAPHY (NR)	$35.50	$26.65	$30.20	420
2839	RETROGRADE MICTURATING CYSTOURETHROGRAPHY (NR)	$66.00	$49.50	$56.10	331
2841	HYSTEROSALPINGOGRAPHY (AU 6 - 407/513) (NR)	$59.00	$44.25	$50.15	52
2843	DISCOGRAPHY - one disc (AU 5 - 406/510) (NR)	$38.50	$28.90	$32.75	5
2844	DISCOGRAPHY using Metrizamide (NR)	$59.00	$44.25	$50.15	—
2845	INTRA-OSSEOUS VENOGRAPHY (NR)	$44.00	$33.00	$37.40	1
2847	MYELOGRAPHY, not covered by Item 2848 (AU 11 - 453/522) (NR)	$116.00	$87.00	$98.60	20
2848	MYELOGRAPHY, using Metrizamide (Amipaque) contrast medium (AU 11 - 453/522) (NR)	$162.00	$121.50	$137.70	3
2849	CISTERNAL PUNCTURE (NR)	$76.00	$57.00	$64.60	—
2851	SINUS OR FISTULA, INJECTION INTO (NR)	$20.00	$15.00	$17.00	4

Item	Description
2852	SIALOGRAPHY (NR) **Fee:** $53.00 **Benefit:** 75% $39.75: 85%/$26 $45.05 2
2853	LYMPHANGIOGRAPHY - one side (NR) **Fee:** $116.00 **Benefit:** 75% $87.00: 85%/$26 $98.60 14
2855	LARYNGOGRAPHY (NR) **Fee:** $59.00 **Benefit:** 75% $44.25: 85%/$26 $50.15 5
2857	PNEUMOMEDIASTINUM (NR) **Fee:** $76.00 **Benefit:** 75% $57.00: 85%/$26 $64.60 5
2859	CHOLEGRAM (CHOLANGIOGRAM) - percutaneous transhepatic (AU 11 - 453/522) (NR) **Fee:** $116.00 **Benefit:** 75% $87.00: 85%/$26 $98.60 4

Jan GP - 280,528

PART 9A - MAGNETIC RESONANCE IMAGING

DIVISION 1

Item	Description
2980	MAGNETIC RESONANCE IMAGING - examination of any part or parts of the body (R) **Fee:** $315.00 **Benefit:** 75% $236.25: 85%/$26 $289.00

PART 11 - NUCLEAR MEDICINE

DIVISION 1

NOTE
(This note should be read in conjunction with explanatory notes preceding this part). Benefits for a nuclear scanning service are only payable when the preliminary examination of the patient, estimation and administration of the dosage and the performance of the scan, are undertaken by a medical practitioner, or on behalf of a medical practitioner in the practitioner's presence, and the compilation of the final report is undertaken by the medical practitioner. Additional benefits will only be attracted for a specialist physician or consultant physician attendance under Part 1 of the Schedule where there is a request for a full medical examination accompanied by a Letter/Notice of Referral.

Item	Description
	MYOCARDIAL PERFUSION STUDY USING THALLIUM - single study for stress OR reperfusion (R)
8727 C	**Fee:** $345.00 **Benefit:** 75% $258.75: 85%/$26 $319.00
8728 NC	**Fee:** $255.00 **Benefit:** 75% $191.25: 85%/$26 $229.00
	MYOCARDIAL PERFUSION STUDY USING THALLIUM - combined study for stress AND reperfusion (R)
8732 C	**Fee:** $545.00 **Benefit:** 75% $408.75: 85%/$26 $519.00
8733 NC	**Fee:** $405.00 **Benefit:** 75% $303.75: 85%/$26 $379.00
	MYOCARDIAL INFARCT-AVID IMAGING STUDY (R)
8734 C	**Fee:** $200.00 **Benefit:** 75% $150.00: 85%/$26 $174.00
8735 NC	**Fee:** $150.00 **Benefit:** 75% $112.50: 85%/$26 $127.50
	GATED CARDIAC BLOOD POOL (equilibrium) STUDY (R)
8740 C	**Fee:** $235.00 **Benefit:** 75% $176.25: 85%/$26 $209.00
	GATED CARDIAC BLOOD POOL STUDY with intervention (R)
8741 C	**Fee:** $290.00 **Benefit:** 75% $217.50: 85%/$26 $264.00
	CARDIAC FIRST PASS BLOOD FLOW STUDY, CARDIAC SHUNT STUDY OR CARDIAC OUTPUT STUDY (not part of other investigation) (R)
8744 C	**Fee:** $176.00 **Benefit:** 75% $132.00: 85%/$26 $150.00
8745 NC	**Fee:** $130.00 **Benefit:** 75% $97.50: 85%/$26 $110.50
	CARDIAC FIRST PASS BLOOD FLOW STUDY, CARDIAC SHUNT STUDY OR CARDIAC OUTPUT STUDY when associated with another item in this Part (R)
8748 C	**Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $84.00
8749 NC	**Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $63.00
	LUNG PERFUSION STUDY (R)
8751 C	**Fee:** $166.00 **Benefit:** 75% $124.50: 85%/$26 $141.10
8752 NC	**Fee:** $124.00 **Benefit:** 75% $93.00: 85%/$26 $105.40

Item	Description
	LUNG VENTILATION STUDY using Xe127 gas (R)
8753 C	**Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
8754 NC	**Fee:** $210.00 **Benefit:** 75% $157.50: 85%/$26 $184.00
	LUNG VENTILATION STUDY using Xe133 gas (R)
8757 C	**Fee:** $156.00 **Benefit:** 75% $117.00: 85%/$26 $132.60
8758 NC	**Fee:** $116.00 **Benefit:** 75% $87.00: 85%/$26 $98.60
	LUNG VENTILATION STUDY using aerosol (R)
8761 C	**Fee:** $192.00 **Benefit:** 75% $144.00: 85%/$26 $166.00
8762 NC	**Fee:** $144.00 **Benefit:** 75% $108.00: 85%/$26 $122.40
	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using either Xe127 or Xe133 gas (R)
8765 C	**Fee:** $300.00 **Benefit:** 75% $225.00: 85%/$26 $274.00
8766 NC	**Fee:** $220.00 **Benefit:** 75% $165.00: 85%/$26 $194.00
	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol (R)
8767 C	**Fee:** $330.00 **Benefit:** 75% $247.50: 85%/$26 $304.00
8768 NC	**Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
	LIVER AND SPLEEN STUDY (colloid) (R)
8771 C	**Fee:** $198.00 **Benefit:** 75% $148.50: 85%/$26 $172.00
8772 NC	**Fee:** $148.00 **Benefit:** 75% $111.00: 85%/$26 $125.80
	RED BLOOD CELL SPLEEN OR LIVER STUDY (R)
8775 C	**Fee:** $200.00 **Benefit:** 75% $150.00: 85%/$26 $174.00
8776 NC	**Fee:** $150.00 **Benefit:** 75% $112.50: 85%/$26 $127.50
	HEPATOBILIARY STUDY (R)
8777 C	**Fee:** $320.00 **Benefit:** 75% $240.00: 85%/$26 $294.00
8778 NC	**Fee:** $240.00 **Benefit:** 75% $180.00: 85%/$26 $214.00
	BOWEL HAEMORRHAGE STUDY (R)
8781 C	**Fee:** $370.00 **Benefit:** 75% $277.50: 85%/$26 $344.00
8782 NC	**Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
	MECKEL'S DIVERTICULUM STUDY (R)
8785 C	**Fee:** $170.00 **Benefit:** 75% $127.50: 85%/$26 $144.50
8786 NC	**Fee:** $128.00 **Benefit:** 75% $96.00: 85%/$26 $108.80
	SALIVARY STUDY (R)
8789 C	**Fee:** $170.00 **Benefit:** 75% $127.50: 85%/$26 $144.50
8790 NC	**Fee:** $128.00 **Benefit:** 75% $96.00: 85%/$26 $108.80
	GASTRO-OESOPHAGEAL REFLUX STUDY (R)
8791 C	**Fee:** $365.00 **Benefit:** 75% $273.75: 85%/$26 $339.00
8792 NC	**Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00

NUCLEAR MEDICINE	
8795 C 8796 NC	OESOPHAGEAL CLEARANCE STUDY (R) **Fee:** $110.00 **Benefit:** 75% $82.50: 85%/$26 $93.50 **Fee:** $82.00 **Benefit:** 75% $61.50: 85%/$26 $69.70
8801 C	GASTRIC EMPTYING STUDY using single tracer (R) **Fee:** $545.00 **Benefit:** 75% $408.75: 85%/$26 $519.00
8802 C	GASTRIC EMPTYING STUDY using dual tracer (R) **Fee:** $580.00 **Benefit:** 75% $435.00: 85%/$26 $554.00
8805 C	RENAL STUDY WITH OR WITHOUT DYNAMIC FLOW STUDY AND WITH OR WITHOUT COMPUTER EXTRACTION OF functional parameters (R) **Fee:** $250.00 **Benefit:** 75% $187.50: 85%/$26 $224.00
8809 C 8810 NC	RENAL STUDY WITH INTERVENTION (R) **Fee:** $305.00 **Benefit:** 75% $228.75: 85%/$26 $279.00 **Fee:** $225.00 **Benefit:** 75% $168.75: 85%/$26 $199.00
8811 C 8812 NC	CYSTOURETEROGRAM (R) **Fee:** $188.00 **Benefit:** 75% $141.00: 85%/$26 $162.00 **Fee:** $142.00 **Benefit:** 75% $106.50: 85%/$26 $120.70
8815 C 8816 NC	TESTICULAR STUDY (R) **Fee:** $124.00 **Benefit:** 75% $93.00: 85%/$26 $105.40 **Fee:** $93.00 **Benefit:** 75% $69.75: 85%/$26 $79.05
8819 C 8820 NC	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT (R) **Fee:** $168.00 **Benefit:** 75% $126.00: 85%/$26 $142.80 **Fee:** $126.00 **Benefit:** 75% $94.50 : 85%/$26 $107.10
8822 C 8823 NC	CEREBRO-SPINAL FLUID TRANSPORT STUDY (R) **Fee:** $660.00 **Benefit:** 75% $495.00: 85%/$26 $634.00 **Fee:** $495.00 **Benefit:** 75% $371.25: 85%/$26 $469.00
8826 C 8827 NC	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) **Fee:** $172.00 **Benefit:** 75% $129.00: 85%/$26 $146.20 **Fee:** $128.00 **Benefit:** 75% $96.00: 85%/$26 $108.80
8830 C 8831 NC	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY (not associated with any other item in this Part) (R) **Fee:** $91.00 **Benefit:** 75% $68.25: 85%/$26 $77.35 **Fee:** $68.00 **Benefit:** 75% $51.00: 85%/$26 $57.80
8832 C 8833 NC	BONE STUDY - whole body (R) **Fee:** $365.00 **Benefit:** 75% $273.75: 85%/$26 $339.00 **Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00

Item	Description
	BONE STUDY - whole body and DYNAMIC BLOOD FLOW OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY (R)
8834 C	**Fee:** $455.00 **Benefit:** 75% $341.25: 85%/$26 $429.00
8835 NC	**Fee:** $345.00 **Benefit:** 75% $258.75: 85%/$26 $319.00
	WHOLE BODY STUDY USING IODINE (R)
8836 C	**Fee:** $415.00 **Benefit:** 75% $311.25: 85%/$26 $389.00
8837 NC	**Fee:** $310.00 **Benefit:** 75% $232.50: 85%/$26 $284.00
	WHOLE BODY STUDY USING GALLIUM (R)
8838 C	**Fee:** $415.00 **Benefit:** 75% $311.25: 85%/$26 $389.00
8839 NC	**Fee:** $310.00 **Benefit:** 75% $232.50: 85%/$26 $284.00
	WHOLE BODY STUDY USING CELLS LABELLED WITH TECHNETIUM (R)
8840 C	**Fee:** $370.00 **Benefit:** 75% $277.50: 85%/$26 $344.00
8841 NC	**Fee:** $275.00 **Benefit:** 75% $206.25: 85%/$26 $249.00
	BONE MARROW STUDY - whole body (R)
8842 C	**Fee:** $365.00 **Benefit:** 75% $273.75: 85%/$26 $339.00
8843 NC	**Fee:** $270.00 **Benefit:** 75% $202.50: 85%/$26 $244.00
	REPEAT WHOLE BODY STUDY on different occasion using same administration of radiopharmaceutical (R)
8844 C	**Fee:** $168.00 **Benefit:** 75% $126.00: 85%/$26 $142.80
8845 NC	**Fee:** $126.00 **Benefit:** 75% $94.50: 85%/$26 $107.10
	LOCALISED BONE OR JOINT STUDY including FLOW AND BLOOD POOL STUDIES (R)
8846 C	**Fee:** $255.00 **Benefit:** 75% $191.25: 85%/$26 $229.00
8847 NC	**Fee:** $190.00 **Benefit:** 75% $142.50: 85%/$26 $164.00
	LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY using gallium (R)
8848 C	**Fee:** $305.00 **Benefit:** 75% $228.75: 85%/$26 $279.00
8849 NC	**Fee:** $225.00 **Benefit:** 75% $168.75: 85%/$26 $199.00
	LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY using cells labelled with technetium (R)
8851 C	**Fee:** $260.00 **Benefit:** 75% $195.00: 85%/$26 $234.00
8852 NC	**Fee:** $194.00 **Benefit:** 75% $145.50: 85%/$26 $168.00
	REPEAT LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY on different occasion using same administration of radiopharmaceutical (R)
8853 C	**Fee:** $112.00 **Benefit:** 75% $84.00: 85%/$26 $95.20
8854 NC	**Fee:** $84.00 **Benefit:** 75% $63.00: 85%/$26 $71.40

Item	Description
	VENOGRAPHY (including blood pool study, active uptake study or dynamic blood flow study) (R)
8855 C	**Fee:** $200.00 **Benefit:** 75% $150.00: 85%/$26 $174.00
8856 NC	**Fee:** $150.00 **Benefit:** 75% $112.50: 85%/$26 $127.50
	LYMPHOSCINTIGRAPHY (R)
8857 C	**Fee:** $260.00 **Benefit:** 75% $195.00: 85%/$26 $234.00
8858 NC	**Fee:** $194.00 **Benefit:** 75% $145.50: 85%/$26 $168.00
	THYROID STUDY (R)
8859 C	**Fee:** $116.00 **Benefit:** 75% $87.00: 85%/$26 $98.60
8860 NC	**Fee:** $86.00 **Benefit:** 75% $64.50: 85%/$26 $73.10
	THYROID UPTAKE STUDY PERFORMED ON GAMMA CAMERA (R)
8861 C	**Fee:** $56.00 **Benefit:** 75% $42.00: 85%/$26 $47.60
8862 NC	**Fee:** $42.00 **Benefit:** 75% $31.50: 85%/$26 $35.70
	PARATHYROID (R)
8863 C	**Fee:** $290.00 **Benefit:** 75% $217.50: 85%/$26 $264.00
	ADRENAL STUDY USING SELENOCHOLESTEROL (R)
8864 C	**Fee:** $665.00 **Benefit:** 75% $498.75: 85%/$26 $639.00
8865 NC	**Fee:** $500.00 **Benefit:** 75% $375.00: 85%/$26 $474.00
	ADRENAL STUDY (not covered by Item 8864/8865) (R)
8866 C	**Fee:** $340.00 **Benefit:** 75% $255.00: 85%/$26 $314.00
8867 NC	**Fee:** $255.00 **Benefit:** 75% $191.25: 85%/$26 $229.00
	SINGLE PHOTON EMISSION TOMOGRAPHY when associated with another item in this Part (R)
8868 C	**Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $168.00
	TEAR DUCT STUDY (R)
8869	**Fee:** $170.00 **Benefit:** 75% $127.50: 85%/$26 $144.50
8870 NC	**Fee:** $128.00 **Benefit:** 75% $96.00: 85%/$26 $108.80
	PARTICLE PERFUSION STUDY (INTRA-ARTERIAL) OR LE VEEN SHUNT STUDY (R)
8871 C	**Fee:** $192.00 **Benefit:** 75% $144.00: 85%/$26 $166.00
8872 NC	**Fee:** $144.00 **Benefit:** 75% $108.00: 85%/$26 $122.40
	STUDY OF REGION OR ORGAN NOT COVERED BY ANY OTHER ITEM IN THIS PART (R) *(See para 11.3 of explanatory notes to this Part)*
8873 C	**Fee:** $11.00 **Benefit:** 75% $8.25: 85%/$26 $9.35
8874 NC	**Fee:** $8.30 **Benefit:** 75% $6.25: 85%/$26 $7.10