Commonwealth Department of
Health, Housing, Local Government and Community Services

Supplement No 1 to

MEDICARE BENEFITS SCHEDULE BOOK

OF 1 NOVEMBER 1992

EFFECTIVE - 1 JULY 1993

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SUPPLEMENT TO 1 NOVEMBER 1992
MEDICARE BENEFITS SCHEDULE BOOK
AMENDMENTS - EFFECTIVE 1 JULY 1993

This supplement provides details of changes to general medical services, diagnostic imaging services and pathology services.

Changes to general medical services result, in the main, from reviews of services undertaken in consultation with the medical profession under the auspices of the Medicare Benefits Consultative Committee. The Schedule amendments involve the introduction of new items, the deletion of obsolete items and amendments to existing items to ensure that the Schedule reflects and supports current proper medical practice in Australia.

The major changes are in the areas of ECG investigations, intensive care, medical oncology and pain management. Other changes flow from evaluations of previous reviews of cardio-thoracic surgery, neurosurgery, plastic and reconstructive surgery and orthopaedic surgery. The fee changes to computerised perimetry investigations follow a revised costing of these services. The remaining amendments to general medical services are incidental changes to correct anomalies and omissions.

The most significant change to diagnostic imaging services is a restructure of Group I1 - Ultrasound, including the introduction of a new Subgroup 4 - Urological, to describe services on an anatomical basis. The revised structure has been developed through the Medicare Benefits Consultative Committee process. The structure, item descriptions and fees will be further reviewed as part of the forthcoming general review of diagnostic imaging services.

Changes to the pathology arrangements result from a review by the Pathology Services Table Committee. Details of these changes are at page 8 of these notes. Please note that items 65007, 66211 and 69217 are included to rectify incorrect fees quoted in the 1 November 1992 MBS reprint.

The amendments apply to services rendered on and after 1 July 1993.

SUMMARY OF CHANGES

Details of new items, ceased items and amendments to existing item numbers and descriptions of services are summarised below.

NEW ITEMS

11701 11702 11708 11711 13809 13812 13819 13821 13824 13827 13830 13833
13836 13918 13921 13924 13930 13933 13936 13939 13942 13945 13948 38410
38447 38449 38455 38460 38462 38464 38466 38468 38469 38486 38487 38492
38572 38613 39013 39125 39126 39128 39131 39134 39323 39331 40301 40801
41910 45552 45753 45754 47916 47943 47975 47978 47981 48632 49357 49517
50104 50127 50130 55030 55031 55032 55033 55034 55035 55036 55037 55038
55039 55040 55041 55042 55043 55044 55045 55048 55049 55050 55051 55052
55053 55056 55057 55300 66331 66335 66337 66339 66341 69261 69263 69265
73287 73289

CEASED ITEMS

11703 13806 13909 13912 38221 38491 40900 47660 47669 47675 55124 69225
73281 73283 73285

RENUMBERED ITEMS

OLD	NEW	OLD	NEW	OLD	NEW	OLD	NEW
13800	13815	38432	38457	38482	38256	55004	55054
13803	13818	38434	38458	38485	38259	55006	55055
13900	14209	38454	38456	45509	45502		
13903	13915	38476	38250	55000	55029		
13906	13927	38479	38253	55003	55028		

AMENDED DESCRIPTIONS (INCLUDES CURRENT AND RENUMBERED ITEMS)

11503 11600 11709 11710 12000 12003 13818 13915 13927 14203 18212 30213
30479 30514 30535 30536 30538 30539 32760 35625 38458 38488 38600 38603
38609 38612 39015 39115 39130 39136 39139 39324 39327 39612 39703 39715
40300 40303 40306 40800 45033 45045 45051 45206 45506 45512 45515 45518
45551 45554 45623 47360 47369 47378 47387 47540 47561 47915 47939 49348
49503 49506 49509 55028 55029 55055 55118 55201 55204 59903 59906 59924
66201 66233 66235 66237 66241 66301 66303 66305 66307 66309 66313 69229
69231 69233 69235 69237 69241 73802 73805 73807 73808

AMENDED ANAESTHETICS

30309 39130

AMENDED FEES

11221 11224 38250 38253 38259 38488 39130 40015 40800 47006 55118 73803
73804

GENERAL CHANGES

Services Rendered "On Behalf Of" Medical Practitioners
It should be noted that chemotherapeutic procedures contained in Subgroup 10, Group T1, Category 3 are now included in the list of services which attract Medicare benefits if the service is rendered by:-

(i) a medical practitioner; or
(ii) a person, other than a medical practitioner, who is employed by a medical practitioner or, in accordance with accepted medical practice, acts under the supervision of a medical practitioner.

Treatment of Simple Fractures
Items 47660, 47669 and 47675 covering treatment of simple toe fractures have been deleted from the Schedule. Medicare benefits for these services will now be attracted on an attendance basis.

MAGNETIC RESONANCE IMAGING

Magnetic resonance imaging (MRI) does not attract a Medicare benefit. Although a Medicare benefit for MRI services was payable in respect of services rendered at certain hospitals during the evaluation period of the technology, the benefit was withdrawn from 29 July 1992.

By agreement with the States, the Commonwealth contributes to the funding of MRI in the form of grants to the States. These grants enable the establishment of 18 publicly funded machines attached to neurosurgical units at major public hospitals, and the payment of radiologists to treat eligible private (non-compensable) patients. The grants were effective from 1 February 1992, rendering the Medicare benefit item superfluous.

Patients eligible for Medicare and private (non-compensable) patients are not charged for MRI services at the recognised (public) hospitals specified hereunder:

Royal North Shore Hospital, St Leonard's NSW
Royal Prince Alfred Hospital, Camperdown, NSW
Royal Melbourne Hospital, Parkville, VIC
St Vincents Hospital, Fitzroy, VIC
Alfred Group of Hospitals, Prahran, VIC
Austin Hospital, Heidelberg, VIC
Princess Alexandra Hospital, Woolloongabba, QLD
Royal Brisbane Hospital, Herston, QLD
Townsville Hospital, Townsville, QLD
Royal Adelaide Hospital, Adelaide, SA
Flinders Medical Centre, Bedford Park, SA
Sir Charles Gairdner Hospital, Nedlands, WA
Royal Perth Hospital, Perth, WA
Royal Hobart Hospital, Hobart, TAS.

In addition, the following recognised (public) hospitals are expected to provide MRI services free-of-charge by early 1994:

Westmead Hospital, Parramatta, NSW
Prince of Wales Hospital, Randwick, NSW
John Hunter Hospital, New Lambton, NSW
Woden Valley Hospital, Woden, ACT.

Details of referral requirements should be obtained from the hospital concerned.

Government policy on MRI is based on the advice of an independent expert committee that access to MRI be improved through the establishment of the publicly funded machines listed above. The policy is concerned to ensure that inappropriate diffusion of this expensive health technology does not occur, and that access to publicly funded MRI is based on demonstrated needs and health outcomes.

Anaesthetic service associated with MRI (item 18013)
Benefits under this item are restricted to anaesthetic services administered in association with MRI services carried out using MRI equipment located at the hospitals listed above.

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

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 July 1993 and continues beyond that date, the old item, 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.

GENERAL EXPLANATORY NOTES

The following changes should be made to the General Explanatory Notes contained in the 1 November 1992 Medicare Benefits Schedule Book.

AMEND Note:

1. OUTLINE OF SCHEME

1.1 **Medicare**

amend second dot point of paragraph 1.1.2 to read:-

. for professional services rendered while hospital treatment (i.e., accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than Medicare hospital patients) ... etc.

1.3 **Addresses of the Health Insurance Commission**

Change address for Tasmania to:-

42 Liverpool Street
HOBART TAS 7000

AMEND Note:

3. VOCATIONAL REGISTRATION OF GENERAL PRACTITIONERS

3.1 **Eligibility**

delete paragraph 3.1.6.

3.3 **Removal from Vocational Register**

add address to which appeals may be sent:-

Vocational Registration Appeal Committee
Department of Health, Housing, Local Government
and Community Services
GPO Box 9848
CANBERRA ACT 2601

AMEND Note:

6. BILLING PROCEDURES

6.1 **Itemised Accounts**

amend paragraph 6.1.2(iii) to read:-

a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment (i.e., accommodation and nursing care) is provided in a hospital or day hospital facility (other than a Medicare hospital patient), that is, the words 'admitted patient' immediately preceding the description of the service or an asterisk '*' directly after an item number where used;

6.5 **Assignment of Benefits (Direct-Billing) Arrangements**

add new paragraph -

6.5.2 Assignment of benefit is not appropriate where the patient has claimed, or may have a right to claim compensation damages in respect of the expense incurred. In these cases, a suitably endorsed patient account should be issued and the patient advised to apply for a provisional payment of Medicare benefit (see paragraph 12.5 of these Notes).

AMEND Note:

9. SCHEDULE FEES AND MEDICARE BENEFITS

9.1 **Schedule Fees and Medicare Benefits**

amend paragraph 9.1.3(i) to read:-

for professional services rendered while hospital treatment (i.e., accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital

facility (other than Medicare hospital patients) ... etc.

In seventh line the reference to "in patient" should be amended to read "admitted patient".

AMEND Note:
12. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS
12.3 Health Screening Services
in last phrase of paragraph 12.3.2 substitute "pathology services associated with clinical ecology" for "pathology tests associated with orthomolecular medicine".

NOTES FOR GUIDANCE - GENERAL MEDICAL SERVICES

The following changes and additions should be made to the explanatory notes contained in Categories 2 and 3 of the 1 November 1992 Medicare Benefits Schedule Book.

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

AMEND Note:
D1.10 Electrocardiographic Monitoring of Ambulatory Patient (item 11709)
substitute "recording" for "monitoring" in heading and in paragraph D1.10.1

CATEGORY 3 - THERAPEUTIC PROCEDURES

DELETE Note:
T1.5 Administration of Cytotoxic Agent (item 13903)

ADD New Note:
T1.7 Intensive Care Management and Procedures (items 13809-13836)

T1.7.1 A recognised Intensive Care Unit is a separate hospital area, equipped and staffed so as to be capable of providing to a patient mechanical ventilation for a period of seven days and invasive cardiovascular monitoring. It must be supported by at least one specialist or consultant physician in intensive care (the intensivist), immediately available during normal working hours, and a registered medical practitioner must be present in the hospital and available immediately to the Unit on a 24 hour-per-day basis. Registered nurse staffing to a minimum of at least 18 hours and more where appropriate and according to the dependency of the patient must be provided. There must be defined admission and discharge policies in relation to the Intensive Care Unit.

several

T1.7.2 Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day.

T1.7.3 Monitoring of central venous and pulmonary arterial pressures on day of insertion are covered by item 13818 and accordingly no additional benefits are payable under item 13819 for such monitoring. Monitoring of pressures subsequent to the first day are covered by item 13819. Where multiple pressures are monitored under item 13819 the actual pressures that are monitored should be identified on the patient's account.

T1.7.4 Medicare benefits are payable in respect to item 13821 only where the intensivist is directly involved in the initiation of ventilation. Where ventilation has been initiated by another practitioner (e.g.. an anaesthetist in the operating room) and the patient is subsequently brought to the ICU, then item 13824 would be the appropriate item, even for the first day of ventilation.

T1.7.5 Routine admissions to an intensive care unit after major surgery do not attract additional benefits in the absence of significant complications.

AMEND Note:
T6.1 General
delete the words "and if the anaesthetist supervises any necessary treatment during the postponement period, such attendances attract benefits either under item 104, 105, 107 or

108." from paragraph T6.1.12 and substitute "this consultation, and any subsequent consultation by the anaesthetist during the postponement period attract benefits under the appropriate attendance item".

✓ AMEND Note:
T8.7 **Aftercare**
add the following at the end of paragraph T8.7.6 -
Likewise, there are a number of services which may be performed during the aftercare period of procedures for pain relief which would also attract benefits. Such services would include all items in Groups T6 and T7 and items 39013, 39100, 39103, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

✓ DELETE Note:
T8.8 **After-care Where Patient is Referred to Intensive Care Unit**

✓ AMEND Note:
T8.11.1 **Treatment of Keratoses, warts etc (items 30189, 30192, 36815)**
add new paragraph -
T8.11.2 The treatment of less than 10 premalignant skin lesions by galvanocautery, electrodesiccation or cryocautery also attracts benefits on an attendance basis.

✓ ADD New Note:
T8.12A **Telangiectases or Starburst Vessels (item 30213)**
T8.12A.1 This item is restricted to treatment on the head and/or neck. If treatment of vessels is performed on other areas of the body for non-cosmetic purposes, application may be made under the provisions of Section 11 of the Health Insurance Act (see paragraph 9.2 of the General Explanatory Notes relating to the lodgement of such claims).

✓ ADD New Note:
T8.23A **Re-operation via Median Sternotomy (item 38640)**
T8.23A.1 Medicare benefits are payable for item 38640 plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula.

✓ AMEND Note:
T8.39 **Liposuction (item 45584)**
to read -
T8.39.1 Medicare benefits for liposuction are generally attracted under item 45584, that is, for the treatment of post traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction. Where liposuction is used in the treatment of other medical conditions ... etc.

NOTES FOR GUIDANCE - DIAGNOSTIC IMAGING SERVICES

The following changes should be made to the explanatory notes contained in Category 5 of the 1 November 1992 Medicare Benefits Schedule Book.

Diagnostic Imaging Services

✓ **Paragraph DIA.1** - in the first line of sixth paragraph delete "55000 and 55006" and substitute "55029, 55031, 55033, 55035, 55037, 55039, 55041, 55043, 55045, 55049, 55051, 55053, 55055 and 55059"

Paragraph DIA.4.1 - delete paragraph and substitute the following -

"There are exemptions from the general written request requirements. These are detailed below."

Paragraph DIA.4.8 - It should be noted that consideration is being given to amending the list of items that can be requested by dental practitioners, oral and maxillofacial surgeons and prosthodontists.

Paragraph DIB.1.3 - delete paragraph and substitute the following -

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

In addition to the normal particulars of the patient, date of service, 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:

- If the professional service is provided by a specialist in diagnostic radiology the name and either the practice address or provider number of the radiologist who provided the service.
- If the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or has received payment or is the assignee under a direct billing agreement in respect of the service provided.
- 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 (rendered by a specialist, other than a specialist in diagnostic radiology, in the course of that specialist practising his or her speciality), 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".

Paragraph DIH.1 - delete paragraph and substitute the following -

DIH.1 Ultrasonic Cross-sectional Echography (items 55028 to 55057)

Items in this range identified with the symbol "(NR)" cover ultrasonic cross-sectional echography where the examination is rendered by a practitioner on his/her own or partner's patient. Items in this range identified with the symbol "(R)" cover the examination where the patient has been referred to a medical practitioner outside the referring practitioner's practice specifically for ultrasound scanning.

CHANGES TO THE PATHOLOGY SERVICES TABLE

Changes to the Rules include the following:

1. The definition of 'approved pathology authority' has been omitted from Subrule 11(1) and added to the definitions under Rule 1(1).

2. In Rule 2.(2) the wording has been tightened but the meaning remains the same.

3. New Rule 2.(3) has been added to ensure that only the appropriate item can be claimed for a particular test or group of tests.

4. In Rule 3A(1) (a) references to cholesterol and triglycerides in item 66201 have been removed as cholesterol and triglycerides no longer appear in item 66201. Rule 3 still applies to tests for cholesterol and triglycerides.

5. New part to Rule 3A which removes the unintentional restriction on the number of tests in a 6 month period for which Medicare benefits are payable.

6. New Rule 3A(2) which exempts item 66217 from Rule 3 to allow payment of three separate item service fees and three Patient Episode Initiation fees.

7. Words were omitted from Rule 6.(a) in the 1 November 1992 reprint of the MBS Book. The correct wording was contained in the 1 November 1992 Regulation.

8. Rule 11(4) has been changed to allow an exemption to the payment of only one Patient Episode Initiation (PEI) fee per patient episode.

9. New Rule 11(4A) defines the circumstances of paying two PEIs for one Patient Episode where either Histology and Cytology tests, or Histology and other tests, or Cytology and other tests are requested by the referring practitioner.

Changes to the items include:

10. new items 66331-66341 to cover lipid testing and the deletion of cholesterol and triglycerides from item 66201;

11. an amendment to the restriction on the number of drug assays which can be performed under item 66233 to 21 tests in any 12 month period;

12. the deletion of item 69225 and inclusion of new items covering the examination of chlamydia - 69261 (culture or DNA probe) and herpes simplex virus - 69263;

13. a new item for the determination of antibodies to hepatitis C - 69265 which removes hepatitis C testing from item 69229;

14. the replacement of items 73281-73285 by 73287-73289 for chromosome studies and identification;

15. an amendment to item 73802 to permit performance of either a haemoglobin estimation, a haematocrit estimation, an erythrocyte count, or one of the other tests listed;

16. new fees for items 73803-73804 to bring them in line with fees elsewhere in the Table;

17. description in item 73805 amended to cover catalase testing of urine; and

18. changes to items 73807-73808 covering microscopical examination of film.

REVISED RULES/SUBRULES

PX.1 Rules for the Interpretation of the Pathology Services Table

Rule 1.(1) - Add:

1.(1) "approved pathology authority" has the same meaning as in Division 4A of Part 11A of the Act.

Rule 2.(2) - Delete and substitute the following:

2.(2) Subject to subrule (3), if

(a) a service is described in 2 or more items; and
(b) subrule (1) does not apply
only the item that provides the lower or lowest fee for the service applies to the service.

Rule 2.(3) - Add New Rule:

2.(3) If an item is expressed to include a pathology service that is specified in another item, the other item does not apply to the service in addition to the first-mentioned item.

Rule 3A.(1)(a) - Delete and substitute the following:

3A.(1) (a) a pathology service specified in item 66201 other than an estimation of fructosamine or lithium; or

Rule 3A.(2) - Add New Rule:

3A.(2) Rule 3 does not apply to any of the following pathology services if, under a request for the service, no more than 6 tests are requested and the tests are performed within 6 months of the request.

Rule 3A.(2A) - Add New Rule:

3A.(2A) Rule 3 does not apply to a pathology service:
(a) to which item 66217 applies; and
(b) for which a specimen is collected on each of 3 days for the purpose of making a valid estimation.

Rule 6.(a) - Delete and substitute the following:

(a) if a pathology service involving the measurement of a substance in urine requires a 24 hour urine collection, or calculation of a substance/creatinine ratio, the service is treated as including any estimation of creatinine in other fluids necessary for the calculation; and

Rule 11.(4) - Delete and substitute the following:

11.(4) Subject to ~~the operation of~~ Subrule (~~4A~~ 6), if one item of items 73901 to 73917 (inclusive) applies to a patient episode, none of the remainder of those items apply to that patient episode.

Rule 11.(4A) - Add New Rule:

11.(4A)

If, in respect of the same patient episode:

(a) services referred to in 1 or more items:
  - (i) in Group P5; and
  - (ii) in 1 of Groups P1, P2, P3, P4, P6, P7 and P8; or

(b) services referred to in 1 or more items:
  - (i) in Group P6; and
  - (ii) in 1 of Groups P1, P2, P3, P4, P5, P7 and P8;

are rendered by an approved pathology practitioner in each of 2 approved pathology authorities, the applicable amount specified in an item in Group P10 is payable to both of the approved pathology practitioners.

Rule 11.(6) - Add New Rule:

11.(6) If more than 1 specimen is collected from a person on the same day for the provision of pathology services:

(a) in accordance with more than 1 request; and

(b) in a single approved pathology authority;

only a single amount specified in the applicable item in Group P10 is payable for the services.

GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

SUBGROUP 2 - OPHTHALMOLOGY

+ 11221	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) performed by a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, bilateral - to a maximum of 2 examinations (including examinations to which item 11224 applies) in any 12 month period **Fee:** $53.00 **Benefit:** 75% = $39.75 85% = $45.05
+ 11224	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) performed by a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, unilateral - to a maximum of 2 examinations (including examinations to which item 11221 applies) in any 12 month period **Fee:** $32.00 **Benefit:** 75% = $24.00 85% = $27.20

SUBGROUP 4 - RESPIRATORY

‡ 11503	MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM, OR OF RESPIRATORY MUSCLE FUNCTION, OR OF VENTILATORY CONTROL MECHANISMS, using measurements of various parameters including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood, electrical activity of muscles (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed *(See para D1.6 of explanatory notes to this Category)* **Fee:** $98.00 **Benefit:** 75% = $73.50 85% = $83.30

SUBGROUP 5 - VASCULAR

‡ 11600	BLOOD PRESSURE MONITORING by intravascular cannula (not being a service associated with a service to which item 13818 or 13819 applies) (AU 4 - 17904) **Fee:** $48.50 **Benefit:** 75% = $36.40 85% = $41.25

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

SUBGROUP 6 - CARDIOVASCULAR

Item	Description
† 11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, including any consultation on the same day **Fee:** $12.20 **Benefit:** 75% = $9.15 85% = $10.40
† 11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $12.20 **Benefit:** 75% = $9.15 85% = $10.40
† 11708	CONTINUOUS ECG RECORDING of ambulatory patient for 12 or more hours, including microprocessor based analysis, interpretation and report of recordings, not being a service associated with a service to which item 11709 applies **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
‡ 11709	CONTINUOUS ECG RECORDING (Holter) of ambulatory patient for 12 or more hours involving recording and storage on a device, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, interpretation and report, including resting ECG and the recording of parameters *(See para D1.10 and D1.10 of explanatory notes to this Category)* **Fee:** $132.00 **Benefit:** 75% = $99.00 85% = $112.20
‡ 11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $36.50 **Benefit:** 75% = $27.40 85% = $31.05
† 11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00

SUBGROUP 9 - ALLERGY TESTING

Item	Description
‡ 12000	SKIN SENSITIVITY TESTING for allergens, USING 1 TO 20 ALLERGENS, not being a service associated with a service to which item 12006 or 12009 applies **Fee:** $27.50 **Benefit:** 75% = $20.65 85% = $23.40
‡ 12003	SKIN SENSITIVITY TESTING for allergens, USING MORE THAN 20 ALLERGENS, not being a service associated with a service to which item 12006 or 12009 applies **Fee:** $41.50 **Benefit:** 75% = $31.15 85% = $35.30

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

SUBGROUP 9 - INTENSIVE CARE MANAGEMENT AND PROCEDURES

Item	Description
† 13809	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including initial and subsequent attendances, electrocardiograms, arterial sampling, bladder catheterisation and blood sampling - management on the first day **Fee:** $215.00 **Benefit:** 75% = $161.25 85% = $187.80
† 13812	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including all attendances, electrocardiograms, arterial sampling, bladder catheterisation and blood sampling - management on each day subsequent to the first day **Fee:** $160.00 **Benefit:** 75% = $120.00 85% = $136.00
* 13815	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) by percutaneous or open exposure not being a service to which item 13318 applies (AU 6 - 17906) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
* ‡ 13818	RIGHT HEART BALLOON FLOTATION using a pulmonary artery catheter, including pulmonary wedge pressure and cardiac output measurement and including monitoring of pulmonary arterial and central venous pressures on the day of insertion - management on the first day **Fee:** $168.00 **Benefit:** 75% = $126.00 85% = $142.80
† 13819	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter by a specialist or consultant physician in an Intensive Care Unit - each day of monitoring for each pressure up to a maximum of 4 pressures (not being a service to which item 11600 or 13818 applies) **Fee:** $48.00 **Benefit:** 75% = $36.00 85% = $40.80
† 13821	MECHANICAL VENTILATION, initiation of, by a specialist or consultant physician in conjunction with subsequent management of ventilatory support on the first day, in an Intensive Care Unit **Fee:** $156.00 **Benefit:** 75% = $117.00 85% = $132.60
† 13824	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by a specialist or consultant physician - not being a service to which item 13809 applies - each day **Fee:** $53.00 **Benefit:** 75% = $39.75 85% = $45.05
† 13827	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices **Fee:** $130.00 **Benefit:** 75% = $97.50 85% = $110.50

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

† 13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day **Fee:** $53.00 **Benefit:** 75% = $39.75 85% = $45.05
† 13833	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on the first day in an Intensive Care Unit **Fee:** $96.00 **Benefit:** 75% = $72.00 85% = $81.60
† 13836	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on each day subsequent to the first day in an Intensive Care Unit **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50

SUBGROUP 10 - CHEMOTHERAPEUTIC PROCEDURES

* ‡ 13915	CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $46.00 **Benefit:** 75% = $34.50 85% = $39.10
† 13918	CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $69.00 **Benefit:** 75% = $51.75 85% = $58.65
† 13921	CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $78.00 **Benefit:** 75% = $58.50 85% = $66.30
† 13924	CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $46.00 **Benefit:** 75% = $34.50 85% = $39.10
* ‡ 13927	CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
† 13930	CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day **Fee:** $83.00 **Benefit:** 75% = $62.25 85% = $70.55
† 13933	CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $92.00 **Benefit:** 75% = $69.00 85% = $78.20
† 13936	CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
† 13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a therapeutic agent or agents, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933 or 13936 applies **Fee:** $69.00 **Benefit:** 75% = $51.75 85% = $58.65
† 13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a therapeutic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915, 13918, 13921, 13924, 13927, 13930, 13933 or 13936 applies **Fee:** $46.00 **Benefit:** 75% = $34.50 85% = $39.10

† 13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE, accessing of **Fee:** $37.00 **Benefit:** 75% = $27.75 85% = $31.45
† 13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $46.00 **Benefit:** 75% = $34.50 85% = $39.10

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

SUBGROUP 12 - OTHER THERAPEUTIC PROCEDURES

‡ 14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture **Fee:** $36.00 **Benefit:** 75% = $27.00 85% = $30.60
* 14209	INTRA-ARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $63.00 **Benefit:** 75% = $47.25 85% = $53.55

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

GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS

‡ 18212	MAINTENANCE of narcotic analgesia referred to in item 18206 by the administration of a narcotic or MAINTENANCE of local anaesthetic referred to in item 18209 through an in situ needle or catheter, when performed other than by the operating surgeon *(See para T7.5 of explanatory notes to this Category)* **Fee:** $28.50 **Benefit:** 75% = $21.40 85% = $24.25

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

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

‡ 30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck, diathermy or sclerosant injection of, including associated consultation - for a session of at least 20 minutes duration **Fee:** $77.00 **Benefit:** 75% = $57.75 85% = $65.45
@ 30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (AU 14 - 17914) **Fee:** $720.00 **Benefit:** 75% = $540.00 85% = $692.80
‡ 30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (AU 12 - 17912) **Fee:** $335.00 **Benefit:** 75% = $251.25 85% = $307.80
‡ 30514	MORBID OBESITY, surgical reversal of procedure to which item 30511 or 30512 applies (AU 22 - 17922) **Fee:** $1,085.00 **Benefit:** 75% = $813.75 85% =$1,057.80
‡ 30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (AU 27 - 17927) **Fee:** $1,195.00 **Benefit:** 75% = $896.25 85% =$1,167.80
‡ 30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck - 1 surgeon (AU 31 - 17931) **Fee:** $1,210.00 **Benefit:** 75% = $907.50 85% =$1,182.80
‡ 30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck - conjoint surgery, principal surgeon (including aftercare) (AU 31 - 17931) **Fee:** $840.00 **Benefit:** 75% = $630.00 85% = $812.80
‡ 30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck - conjoint surgery, co-surgeon **Fee:** $615.00 **Benefit:** 75% = $461.25 85% = $587.80

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

SUBGROUP 3 - VASCULAR

‡	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (AU 9 - 17909)
32760	**Fee:** $285.00 **Benefit:** 75% = $213.75 85% = $257.80

SUBGROUP 4 - GYNAECOLOGICAL

‡	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (AU 9 - 17909)
35625	**Fee:** $425.00 **Benefit:** 75% = $318.75 85% = $397.80

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

SUBGROUP 6 - CARDIO-THORACIC

* + 38250	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion of (AU 12 - 17912) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $422.80
* + 38253	PERMANENT PACEMAKER, insertion or replacement of (AU 12 - 17912) **Fee:** $180.00 **Benefit:** 75% = $135.00 85% = $153.00
* 38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (AU 11 - 17911) **Fee:** $188.00 **Benefit:** 75% = $141.00 85% = $160.80
* + 38259	PERMANENT DUAL CHAMBER TRANSVENOUS ELECTRODES, insertion of (AU 12 - 17912) **Fee:** $590.00 **Benefit:** 75% = $442.50 85% = $562.80
† 38410	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (AU 7 - 17907) **Fee:** $116.00 **Benefit:** 75% = $87.00 85% = $98.60
† 38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (AU 28 - 17928) **Fee:** $1,080.00 **Benefit:** 75% = $810.00 85% =$1,052.80
† 38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (AU 32 - 17932) **Fee:** $1,510.00 **Benefit:** 75% =$1,132.50 85% =$1,482.80
† 38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (AU 40 - 17940) **Fee:** $1,640.00 **Benefit:** 75% =$1,230.00 85% =$1,612.80
* 38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (AU 28 - 17928) **Fee:** $1,080.00 **Benefit:** 75% = $810.00 85% =$1,052.80
* 38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (AU 16 - 17916) **Fee:** $1,010.00 **Benefit:** 75% = $757.50 85% = $982.80
* ‡ 38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (AU 16 - 17916) **Fee:** $535.00 **Benefit:** 75% = $401.25 85% = $507.80
† 38460	STERNAL WIRE OR WIRES, removal of (AU 8 - 17908) **Fee:** $194.00 **Benefit:** 75% = $145.50 85% = $166.80

Item	Description
† 38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (AU 12 - 17912) **Fee:** $230.00 **Benefit:** 75% = $172.50 85% = $202.80
† 38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (AU 12 - 17912) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $222.80
† 38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (AU 18 - 17918) **Fee:** $675.00 **Benefit:** 75% = $506.25 85% = $647.80
† 38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (AU 28 - 17928) **Fee:** $1,040.00 **Benefit:** 75% = $780.00 85% =$1,012.80
† 38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (AU 32 - 17932) **Fee:** $1,210.00 **Benefit:** 75% = $907.50 85% =$1,182.80
† 38486	**VALVULAR PROCEDURES** AORTIC VALVE, decalcification of (AU 32 - 17932) **Fee:** $1,210.00 **Benefit:** 75% = $907.50 85% =$1,182.80
† 38487	MITRAL VALVE, open valvotomy of (AU 32 - 17932) **Fee:** $1,210.00 **Benefit:** 75% = $907.50 85% =$1,182.80
‡ + 38488	VALVE REPLACEMENT with BIOPROSTHESIS, MECHANICAL PROSTHESIS or UNSTENTED XENOGRAFT (AU 32 - 17932) **Fee:** $1,345.00 **Benefit:** 75% =$1,008.75 85% =$1,317.80
† 38492	VALVE REPLACEMENT WITH ALLOGRAFT, subcoronary or cylindrical implant (AU 36 - 17936) **Fee:** $1,600.00 **Benefit:** 75% =$1,200.00 85% =$1,572.80
† 38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (AU 25 - 17925) **Fee:** $1,400.00 **Benefit:** 75% =$1,050.00 85% =$1,372.80
‡ 38600	**CIRCULATORY SUPPORT PROCEDURES** CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (AU 16 - 17916) **Fee:** $1,080.00 **Benefit:** 75% = $810.00 85% =$1,052.80

‡ 38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (AU 13 - 17913) **Fee:** $675.00 **Benefit:** 75% = $506.25 85% = $647.80
‡ 38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (AU 14 - 17914) **Fee:** $340.00 **Benefit:** 75% = $255.00 85% = $312.80
‡ 38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (AU 14 - 17914) **Fee:** $380.00 **Benefit:** 75% = $285.00 85% = $352.80
† 38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (AU 20 - 17920) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $447.80

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

SUBGROUP 7 - NEUROSURGICAL

† 39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves **Fee:** $77.00 **Benefit:** 75% = $57.75 85% = $65.45
‡ 39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (AU 12 - 17912) **Fee:** $265.00 **Benefit:** 75% = $198.75 85% = $237.80
‡ 39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (AU 6 - 17906) **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50
† 39125	SPINAL CATHETER, insertion of - for an automated infusion device (AU 8 - 17908) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $182.80
† 39126	AUTOMATED SUBCUTANEOUS INFUSION DEVICE, insertion of (AU 8 - 17908) **Fee:** $255.00 **Benefit:** 75% = $191.25 85% = $227.80
† 39128	AUTOMATED SUBCUTANEOUS INFUSION DEVICE AND SPINAL CATHETER, insertion of (AU 11 - 17911) **Fee:** $465.00 **Benefit:** 75% = $348.75 85% = $437.80
‡ @ + 39130	PERCUTANEOUS EPIDURAL ELECTRODE, insertion of 1 or more of - for spinal stimulation (AU 10 - 17910) **Fee:** $430.00 **Benefit:** 75% = $322.50 85% = $402.80
† 39131	PERCUTANEOUS EPIDURAL ELECTRODES, management, adjustment, electronic programming and trial of stimulation of, by a medical practitioner - each day **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
† 39134	SPINAL NEUROSTIMULATOR RECEIVER or pulse generator, subcutaneous placement of (AU 8 - 17908) **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $212.80
‡ 39136	PERCUTANEOUS EPIDURAL IMPLANT for management of pain, removal of (AU 7 - 17907) **Fee:** $112.00 **Benefit:** 75% = $84.00 85% = $95.20
‡ 39139	EPIDURAL ELECTRODE for management of pain, insertion of 1 or more of by laminectomy, including implantation of pulse generator (1 or 2 stages) (AU 18 - 17918) **Fee:** $760.00 **Benefit:** 75% = $570.00 85% = $732.80

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

Item	Description
† 39323	PERCUTANEOUS NEUROTOMY by cryoneurotomy or radiofrequency lesion generator, not being a service to which another item applies (AU 8 - 17908) **Fee:** $194.00 **Benefit:** 75% = $145.50 85% = $166.80
‡ 39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (AU 8 - 17908) **Fee:** $194.00 **Benefit:** 75% = $145.50 85% = $166.80
‡ 39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation (AU 10 - 17910) **Fee:** $335.00 **Benefit:** 75% = $251.25 85% = $307.80
† 39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (AU 7 - 17907) **Fee:** $194.00 **Benefit:** 75% = $145.50 85% = $166.80
‡ 39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (AU 14 - 17914) **Fee:** $790.00 **Benefit:** 75% = $592.50 85% = $762.80
‡ 39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (AU 10 - 17910) **Fee:** $365.00 **Benefit:** 75% = $273.75 85% = $337.80
‡ 39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (AU 25 - 17925) **Fee:** $1,400.00 **Benefit:** 75% =$1,050.00 85% =$1,372.80
+ 40015	SUBTEMPORAL DECOMPRESSION (AU 26 - 17926) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $422.80
‡ 40300	**SPINAL DISORDERS** INTERVERTEBRAL DISC OR DISCS, laminectomy for removal of (AU 12 - 17912) **Fee:** $675.00 **Benefit:** 75% = $506.25 85% = $647.80
† 40301	INTERVERTEBRAL DISC OR DISCS, microsurgical discectomy of (AU 12 - 17912) **Fee:** $675.00 **Benefit:** 75% = $506.25 85% = $647.80
‡ 40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, laminectomy for - 1 level (AU 13 - 17913) **Fee:** $770.00 **Benefit:** 75% = $577.50 85% = $742.80
‡ 40306	SPINAL STENOSIS, laminectomy for, involving more than 1 vertebral interspace (disc level) (AU 16 - 17916) **Fee:** $1,010.00 **Benefit:** 75% = $757.50 85% = $982.80

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

‡	**STEREOTACTIC PROCEDURES** +
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (AU 17 - 17917) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $422.80
† 40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts (AU 25 - 17925) **Fee:** $1,230.00 **Benefit:** 75% = $922.50 85% =$1,202.80

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

SUBGROUP 8 - EAR, NOSE AND THROAT

† 41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (AU 16 - 17916) **Fee:** $275.00 **Benefit:** 75% = $206.25 85% = $247.80

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

SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY

Item	Description
‡ 45033	ANGIOMA, large or involving deeper tissue including facial muscle or breast, excision and suture of (AU 9 - 17909) **Fee:** $170.00 **Benefit:** 75% = $127.50 85% = $144.50
‡ 45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (AU 16 - 17916) **Fee:** $215.00 **Benefit:** 75% = $161.25 85% = $187.80
‡ 45051	CONTOUR RECONSTRUCTION for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (AU 10 - 17910) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $335.00 **Benefit:** 75% = $251.25 85% = $307.80
‡ 45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals (AU 12 - 17912) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $242.80
* 45502	MICROVASCULAR ANASTOMOSIS of artery or vein using microsurgical techniques, for reimplantation of limb or digit or free transfer of tissue (AU 38 - 17938) **Fee:** $1,250.00 **Benefit:** 75% = $937.50 85% =$1,222.80
‡ 45506	SCAR, of face or neck, not more than 3 cms in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (AU 8 - 17908) **Fee:** $154.00 **Benefit:** 75% = $115.50 85% = $130.90
‡ 45512	SCAR, of face or neck, more than 3 cms in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (AU 9 - 17909) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $182.80
‡ 45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (AU 10 - 17910) **Fee:** $132.00 **Benefit:** 75% = $99.00 85% = $112.20
‡ 45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her speciality (AU 12 - 17912) **Fee:** $158.00 **Benefit:** 75% = $118.50 85% = $134.30

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

‡ 45551	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule, as an independent procedure (AU 10 - 17910) **Fee:** $315.00 **Benefit:** 75% = $236.25 85% = $287.80
† 45552	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule and replacement of prosthesis (AU 13 - 17913) **Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $422.80
‡ 45554	BREAST PROSTHESIS, replacement of, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (AU 15 - 17915) **Fee:** $495.00 **Benefit:** 75% = $371.25 85% = $467.80
‡ 45623	PTOSIS of eyelid (unilateral), correction of (AU 12 - 17912) **Fee:** $550.00 **Benefit:** 75% = $412.50 85% = $522.80
† 45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (AU 50 - 17950) **Fee:** $1,535.00 **Benefit:** 75% =$1,151.25 85% =$1,507.80
† 45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III(Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (AU 58 - 17958) **Fee:** $1,840.00 **Benefit:** 75% =$1,380.00 85% =$1,812.80

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

SUBGROUP 15 - ORTHOPAEDIC

+ 47006	CLAVICLE, treatment of dislocation of, by open reduction (AU 9 - 17909) **Fee:** $120.00 **Benefit:** 75% = $90.00 85% = $102.00
‡ 47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (AU 6 - 17906) **Fee:** $93.00 **Benefit:** 75% = $69.75 85% = $79.05
‡ 47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (AU 6 - 17906) **Fee:** $120.00 **Benefit:** 75% = $90.00 85% = $102.00
‡ 47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (AU 6 - 17906) **Fee:** $120.00 **Benefit:** 75% = $90.00 85% = $102.00
‡ 47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (AU 6 - 17906) **Fee:** $192.00 **Benefit:** 75% = $144.00 85% = $164.80
‡ 47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (AU 9 - 17909) **Fee:** $152.00 **Benefit:** 75% = $114.00 85% = $129.20
‡ 47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564, 47567, 47570 or 47573 applies (AU 10 - 17910) **Fee:** $192.00 **Benefit:** 75% = $144.00 85% = $164.80
‡ 47915	INGROWING nail of finger or toe, wedge resection for, including removal of segment of nail, ungual fold and portion of the nail bed (AU 6 - 17906) **Fee:** $120.00 **Benefit:** 75% = $90.00 85% = $102.00
† 47916	INGROWING nail of finger or toe, partial resection of nail, including phenolisation but not including excision of nail bed (AU 5 - 17905) **Fee:** $60.00 **Benefit:** 75% = $45.00 85% = $51.00
‡ 47939	LIMB LENGTHENING (first stage), osteotomy for, including application of distracting apparatus (AU 12 - 17912) **Fee:** $565.00 **Benefit:** 75% = $423.75 85% = $537.80
† 47943	LIMB LENGTHENING requiring slow distraction and application of ring fixator, not being a service to which item 47939 applies (AU 26 - 17926) **Fee:** $900.00 **Benefit:** 75% = $675.00 85% = $872.80
† 47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (AU 9 - 17909) **Fee:** $260.00 **Benefit:** 75% = $195.00 85% = $232.80

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

Item	Description
† 47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (AU 7 - 17907) **Fee:** $158.00 **Benefit:** 75% = $118.50 85% = $134.30
† 47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (AU 5 - 17905) **Fee:** $106.00 **Benefit:** 75% = $79.50 85% = $90.10
† 48632	SCOLIOSIS, congenital, vertebral resection and fusion for (AU 30 - 17930) **Fee:** $1,100.00 **Benefit:** 75% = $825.00 85% =$1,072.80
‡ 49348	HIP, congenital dislocation of, treatment of, by closed reduction (AU 5 - 17905) **Fee:** $112.00 **Benefit:** 75% = $84.00 85% = $95.20
† 49357	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (AU 8 - 17908) **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $222.80
‡ 49503	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure not being a service to which another item in this Group applies - any 1 procedure (AU 10 - 17910) **Fee:** $345.00 **Benefit:** 75% = $258.75 85% = $317.80
‡ 49506	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure not being a service to which another item in this Group applies - any 2 or more procedures (AU 12 - 17912) **Fee:** $515.00 **Benefit:** 75% = $386.25 85% = $487.80
‡ 49509	KNEE, total synovectomy or arthrodesis of (AU 12 - 17912) **Fee:** $530.00 **Benefit:** 75% = $397.50 85% = $502.80
† 49517	KNEE, hemiarthroplasty of (AU 20 - 17920) **Fee:** $850.00 **Benefit:** 75% = $637.50 85% = $822.80
† 50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $192.80
† 50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (AU 15 - 17915) **Fee:** $495.00 **Benefit:** 75% = $371.25 85% = $467.80
† 50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (AU 9 - 17909) **Fee:** $220.00 **Benefit:** 75% = $165.00 85% = $192.80

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

	GROUP I1 - ULTRASOUND
	SUBGROUP 1 - GENERAL
* ‡ 55028	HEAD, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
* ‡ 55029	HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55030	ORBITAL CONTENTS, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55031	ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55032	NECK, 1 or more structures of, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55033	NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55034	BREAST, 1 or both, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75

† 55035	BREAST, 1 or both, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55036	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55037	ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55038	URINARY TRACT, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55039	URINARY TRACT, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55040	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55041	PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner for ultrasonic examination - each ultrasonic examination, not exceeding 2 examinations in any 1 pregnancy, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05

Item	Description
† 55042	PELVIS, female, ultrasound scan of, by any or all approaches, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55043	PELVIS, female, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55044	PELVIS, male, ultrasound scan of, by any or all approaches, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55045	PELVIS, male, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55048	SCROTUM, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55049	SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
† 55050	MUSCULO - SKELETAL, 1 or more regions, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55051	MUSCULO - SKELETAL, 1 or more regions, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05

† 55052	JOINT, 1 or more, ultrasound scan of, performed by, or on behalf of, a medical practitioner where the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which another item in this Group applies 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) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
† 55053	JOINT, 1 or more, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
* 55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this Group applies (R) **Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75
* ‡ 55055	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $57.00 **Benefit:** 75% = $42.75 85% = $48.45
† 55056	ULTRASOUND SCAN not otherwise specified, not being a service associated with a service to which another item in this Group applies (R) **Fee:** $20.50 **Benefit:** 75% = $15.40 85% = $17.45
† 55057	ULTRASOUND SCAN not otherwise specified, not being a service associated with a service to which another item in this Group applies (NR) **Fee:** $5.00 **Benefit:** 75% = $3.75 85% = $4.25

SUBGROUP 2 - CARDIAC

‡ +

HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least 2 oesophageal windows:

(i) performed using a mechanical sector scanner or phased array transducer; with
   (a) measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous Doppler techniques;
   (b) real time colour flow mapping from at least 2 oesophageal windows; and
   (c) recordings on video tape; and

(ii) not being a service associated with a service to which any item in Group I1, Subgroup 1 applies (R)

55118 **Fee:** $240.00 **Benefit:** 75% = $180.00 85% = $212.80

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

SUBGROUP 3 - VASCULAR

‡	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) or peripheral vessels (with or without intra-abdominal studies necessary for views of the lower aorta) or intra-thoracic or intra-abdominal vascular structures (excluding cardiac and pregnancy related studies), not being a service associated with a service to which items in Group I1, Subgroup 1 and Subgroup 4 apply - 1 examination and report (R) *(See para DIH. of explanatory notes to this Category)*
55201	**Fee:** $164.00 **Benefit:** 75% = $123.00 85% = $139.40
‡	- 2 or more examinations of the kind referred to in item 55201 and report, not being a service associated with a service to which items in Group I1, Subgroup 1 and Subgroup 4 apply (R) *(See para DIH. of explanatory notes to this Category)*
55204	**Fee:** $280.00 **Benefit:** 75% = $210.00 85% = $252.80

SUBGROUP 4 - UROLOGICAL

Item	Description
†	PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed: (a) personally by a medical practitioner using a transducer probe or probes able to operate within a frequency range of 7 to 7.5 megahertz and able to obtain both transverse and longitudinal scans; and (b) following a digital rectal examination of the prostate by that medical practitioner; and (c) on a patient who has been assessed by a specialist surgeon or consultant physician who has: (i) examined the patient in the 60 days prior to the scan; and (ii) recommended the scan for the management of the patient's current prostatic disease (R)
55300	**Fee:** $95.00 **Benefit:** 75% = $71.25 85% = $80.75

GROUP I3 - DIAGNOSTIC RADIOLOGY

SUBGROUP 13 - ANGIOGRAPHY AND REPORT

Item	Description
‡ 59903	SERIAL ANGIOCARDIOGRAPHY (SINGLE PLANE) - each series (R) (AU 8 - 17908) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
‡ 59906	SERIAL ANGIOCARDIOGRAPHY (BI-PLANE) - each series (R) (AU 8 - 17908) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
‡ 59924	SELECTIVE ARTERIOGRAPHY - per injection and film or data aquisition run (R) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15

GROUP P1 - HAEMATOLOGY

Item	Description
65007	Full blood examination consisting of items 65003 and 65005 **Fee:** $17.30 **Benefit:** 75% = $13.00 85% = $14.75

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

GROUP P2 - CHEMICAL

Item	Description
‡ 66201	Quantitative estimation in serum, plasma, urine or other body fluid, by any method except by reagent strip with or without reflectance meter or electrophoresis, when not performed as specified in item 66331, of - alanine aminotransferase, albumin, alkaline phosphatase, amylase, aspartate aminotransferase, bicarbonate, bilirubin (total and any fractions), calcium (total, dialysed or ionised), chloride, creatine kinase, creatine kinase isoenzymes (when not performed as specified in item 66245), creatinine, fructosamine, gamma glutamyl transpeptidase, globulin, glucose, lactate dehydrogenase, lipase, lithium, magnesium, phosphate, potassium, total protein, sodium, urate, urea - 1 estimation **Fee:** $9.80 **Benefit:** 75% = $7.35 85% = $8.35
66211	6 or more estimations specified in item 66201 **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
‡ 66233	Drug assays - including all qualitative and quantitative estimations on blood, urine or other body fluid for a drug, or drugs, of abuse or a therapeutic drug on a sample collected from a patient participating in a drug abuse treatment program, or being treated for drug effects or under a court order or parole board supervision, but excluding the detection of nicotine and metabolites in smoking withdrawal programs - each assay to a maximum of 21 assays in any 12 month period **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00
‡ 66235	Drug assay - quantitative estimation on blood or other body fluid by any method or methods of a drug being used therapeutically for the patient from whom the specimen was taken and not elsewhere specified in the Schedule - 1 estimation (This fee applies where a laboratory performs the only drug assay specified on the request form or performs 1 assay and refers the rest to the laboratory of a separate APA) **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00
‡ 66237	2 estimations specified in item 66235 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 2 of the drug assays specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $28.00 **Benefit:** 75% = $21.00 85% = $23.80
‡ 66241	Estimations specified in any of items 66235 to 66239 (inclusive), if the number of estimations relating to the same patient episode does not exceed 3 - each estimation to a maximum of 2 estimations (This fee applies to the laboratory of a different APA to the first laboratory, which has referred to it the remainder of the drug assays specified on the request form. The PEI applicable to this item is 73921, the "Specimen Referred Fee".) **Fee:** $8.00 **Benefit:** 75% = $6.00 85% = $6.80

Item change to 66343

‡ 66301	Hormones and hormone binding proteins, quantitative estimation by any method of - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, cyclic AMP, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, human placental lactogen, hydroxyprogesterone, insulin, LH, oestradiol, oestriol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IgF1), free or total testosterone, TSH (where not requested as part of a thyroid function test), urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (antidiuretic hormone) - 1 estimation (This fee applies where a laboratory performs the only hormone estimation specified on the request form or performs 1 estimation and refers the rest to the laboratory of a separate APA) **Fee:** $30.80 **Benefit:** 75% = $23.10 85% = $26.20
‡ 66303	2 estimations specified in item 66301 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 2 of the hormone estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $41.60 **Benefit:** 75% = $31.20 85% = $35.40
‡ 66305	3 estimations specified in item 66301 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 3 of the hormone estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $52.40 **Benefit:** 75% = $39.30 85% = $44.55
‡ 66307	4 estimations specified in item 66301 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 4 of the hormone estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $63.20 **Benefit:** 75% = $47.40 85% = $53.75
‡ 66309	5 estimations specified in item 66301 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 5 of the hormone estimations specified on the request form refers the remainder to the laboratory of a separate APA.) **Fee:** $74.00 **Benefit:** 75% = $55.50 85% = $62.90
‡ 66313	Estimations specified in any of items 66301 to 66311 (inclusive), if the number of estimations relating to the same patient episode does not exceed 6 - each estimation to a maximum of 5 estimations (This fee applies to the laboratory of a different APA to the first laboratory, which has referred to it the remainder of the hormone estimations specified on the request form. The PEI applicable to this item is 73921, the "Specimen Referred Fee".) **Fee:** $10.80 **Benefit:** 75% = $8.10 85% = $9.20

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

Item	Description
† 66331	Quantitative estimation in serum, plasma, urine or other body fluid of cholesterol or triglycerides or both, except by reagent strip with or without reflectance meter or electrophoresis **Fee:** $11.60 **Benefit:** 75% = $8.70 85% = $9.90
† 66335	Services specified in item 66331 and 1 estimation specified in item 66201 **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
† 66337	Services specified in item 66331 and 2 estimations specified in item 66201 **Fee:** $15.95 **Benefit:** 75% = $12.00 85% = $13.60
† 66339	Services specified in item 66331 and 3 estimations specified in item 66201 **Fee:** $18.00 **Benefit:** 75% = $13.50 85% = $15.30
† 66341	Services specified in item 66331 and 4 or more estimations specified in item 66201 **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10

GROUP P3 - MICROBIOLOGY

Item	Description
69217	Urine examination including serial examination, with cell count, relevant stained preparations, culture, colony count by any method, identification of any cultured pathogens, antibiotic sensitivity testing when necessary, and with any relevant general examination for pH, specific gravity, blood, albumin, urobilinogen, sugar, acetone or bile salts (simple culture by dip slide is excluded from this item) **Fee:** $20.10 **Benefit:** 75% = $15.10 85% = $17.10
‡ 69229	Antibodies to microbial or exogenous antigens not elsewhere specified in the Schedule - estimation of 1 antibody (This fee applies where a laboratory performs the only antibody estimation specified on the request form or performs 1 estimation and refers the rest to the laboratory of a separate APA) **Fee:** $13.60 **Benefit:** 75% = $10.20 85% = $11.60
‡ 69231	2 estimations specified in item 69229 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 2 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $20.80 **Benefit:** 75% = $15.60 85% = $17.70
‡ 69233	3 estimations specified in item 69229 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $28.00 **Benefit:** 75% = $21.00 85% = $23.80
‡ 69235	4 estimations specified in item 69229 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $35.20 **Benefit:** 75% = $26.40 85% = $29.95
‡ 69237	5 estimations specified in item 69229 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 5 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $42.40 **Benefit:** 75% = $31.80 85% = $36.05

Item	Description
‡ 69241	Estimations specified in any of items 69229 to 69239 (inclusive), if the number of estimations relating to the same patient episode does not exceed 6 - each estimation to a maximum of 5 estimations (This fee applies to the laboratory of a different APA to the first laboratory, which has referred to it the remainder of the antibody estimations specified on the request form. The PEI applicable to this item is 73921, the "Specimen Referred Fee".) **Fee:** $7.20 **Benefit:** 75% = $5.40 85% = $6.15
† 69261	Examination for chlamydia by culture or by the demonstration of chlamydial nucleic acid using a DNA probe in material collected directly from a patient, including a service specified in item 69221, 69223 or 69263 **Fee:** $17.60 **Benefit:** 75% = $13.20 85% = $15.00
† 69263	Examination for herpes simplex virus of 1 or more types in material collected directly from a patient by culture, including a service specified in item 69221, 69223 or 69261 **Fee:** $27.50 **Benefit:** 75% = $20.65 85% = $23.40
† 69265	Determination of antibodies to hepatitis C **Fee:** $13.60 **Benefit:** 75% = $10.20 85% = $11.60

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

GROUP P7 - CYTOGENETICS

† 73287	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or by fragile X-site determination of 1 or more of amniotic fluid, bone marrow, skin and any other tissue or fluid ~~excluding~~ except blood - 1 or more estimations **Fee:** $320.00 **Benefit:** 75% = $240.00 85% = $292.80
† 73289	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or by fragile X-site determination of blood - 1 or more estimations **Fee:** $290.00 **Benefit:** 75% = $217.50 85% = $262.80

GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS

Item	Description
‡ 73802	Blood count consisting of leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin estimation, haematocrit estimation or erythrocyte count - 1 procedure **Fee:** $4.20 **Benefit:** 75% = $3.15 85% = $3.60
+ 73803	2 procedures specified in item 73802 **Fee:** $5.60 **Benefit:** 75% = $4.20 85% = $4.80
+ 73804	3 or more procedures specified in item 73802 **Fee:** $7.60 **Benefit:** 75% = $5.70 85% = $6.50
‡ 73805	Urine - microscopical examination of, or catalase test for, bacteria and cells, whether stained or not **Fee:** $4.20 **Benefit:** 75% = $3.15 85% = $3.60
‡ 73807	Microscopical examination of wet film other than urine, including any relevant stain **Fee:** $6.30 **Benefit:** 75% = $4.75 85% = $5.40
‡ 73808	Microscopical examination of Gram stained film, including any examination specified in items 73805 and 73807 **Fee:** $8.00 **Benefit:** 75% = $6.00 85% = $6.80

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