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

Medicare Benefits Schedule Book

Operating from 1 November 1993

Australian Government Publishing Service
Canberra

ISBN 0 644 29234 2

This work was produced from camera-ready copy. There has been no input by the editorial section of the Australian Government Publishing Service.

Printed for AGPS by Southweb.

FOREWORD

This book provides information on the arrangements for the payment of Medicare benefits for professional services rendered by registered medical practitioners and approved dental practitioners (oral surgeons). These arrangements operate under the Health Insurance Act 1973 (as amended). However, at the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

The book is divided into the following sections :-

- **General Explanatory Notes**
  (includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)

- **General Medical Services** comprising
  - **Professional Attendances** (Category 1) - **(buff edging)**
  - **Diagnostic Services** (Category 2) - **(blue edging)**
  - **Therapeutic Procedures** (Category 3) - **(red edging)**
  (includes specific explanatory notes preceding each Category)

- **Index to General Medical Services (green edging)**

- **Approved Dental Practitioner Services** (Category 4) - **(grey edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

- **Diagnostic Imaging Services** (Category 5) - **(purple edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

- **Pathology Services** (Category 6) - **(yellow edging)**
  (includes an outline of these arrangements, specific explanatory notes and an index)

Schedules of Services
Each professional service contained in the book has been allocated a unique item number, which may be found by reference to the alphabetical listing of services in the relevant index. (For services not listed in the Schedule see paragraph 10 of the General Explanatory Notes)

Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item if applicable. In the case of services which have an associated anaesthetic, the number of relevant anaesthetic units and the anaesthetic item number, are also shown, eg (AU 5 - 17905).

In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her specialty and the patient has been referred. The item identified by the letter "G" applies in any other circumstance.

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons). For conditions of referral see paragraph 5. of the General Explanatory Notes.

Differential fees and benefits also apply to services listed in Category 5 (Diagnostic Imaging Services). The conditions relating to these services are set out in the Category 5 notes.

Structure of Schedule of Services
The book has been structured to group professional services according to their general nature, while some have been further organised into sub-groups according to the particular nature of the services concerned. For example, Group T8 covering surgical operations has been divided into fifteen sub-groups corresponding generally to the usual classification of surgical procedures. Certain sub-groups are further classified to allow for suitable grouping of specific services, eg. varicose veins, operations on the prostate (see list of contents at the beginning of each Category).

The professional services have been expressed in general terms, even though the name of one or more physicians or surgeons may have become linked, by usage, with a particular procedure. For example, 'Bassini's operation' is not listed as such in the Schedule but is covered by 'repair of inguinal hernia' in Items 30612/30614.

Explanatory Notes
Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the book, while notes relating to specific items are located at the beginning of each Category.

While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

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

NSW - 02 5612212	WA - 09 2638126 or 2638127
VIC - 03 2843661	TAS - 002 321400
QLD - 07 3607215	ACT - 06 2036360
SA - 08 2018629	NT - use New South Wales inquiry number

It is also important that the HIC be notified promptly of changes to mailing addresses to ensure receipt of the Medicare Benefits Schedule book and up-dates. Failure to notify changes could result in non-receipt of the book. Addresses of the Commission are listed on page 1 of this book.

Distribution of the Medicare Benefits Schedule Book
Enquiries concerning the distribution of the Medicare Benefits Schedule book should be directed to the Department of Health, Housing, Local Government and Community Services. Addresses of the Department are listed on page 4 of this book.

Future Editions of the Medicare Benefits Schedule Book
The Department welcomes any suggestions for improvements on the layout of the Medicare Benefits Schedule book from individual practitioners. Any suggestions should be forwarded to:- The Director, Schedules Section, Medicare Benefits Branch, GPO Box 9848, Canberra ACT 2601.

SUMMARY OF CHANGES INCLUDED IN THIS EDITION

General Fee Increase
Schedule fees have been increased by up to 1.09% for all services (except for some unreferred attendance items covering consultations by medical practitioners other than general practitioners), effective from 1 November 1993.

New rounding rules take effect from 1 November 1993 and as a result individual fee increases will vary. After the application of fee increases, all unrounded Schedule fees will now be rounded to the nearest 5 cents. Where adjusted fees fall exactly on the division between rounding up and rounding down, the fees will be rounded down.

Benefits calculated from rounded fees will be rounded in the normal manner, i.e. to the nearest higher 5 cents.

Renaming of General Practitioner Items and Regrouping of Category 1 - Attendances
Items previously available only to vocationally registered general practitioners are now also available to Fellows of the Royal Australian College of General Practitioners (FRACGP) and to practitioners enrolled in a post graduate general practice training program during the period of their general practice placement. These items (3-51) are renamed "General Practitioner Attendances" (Group A1).

Items 52-96 are renamed "Other Non-Referred Attendances" and become Group A2. Items for "Emergency After-Hours Attendances" become Group A3. The remaining Groups in Category 1 are consequentially renumbered to accommodate the new Groups.

Review of Schedule Services
A number of reviews of services in the Schedule have been undertaken in consultation with the relevant professional groups. The main changes relate to the following:-

- changes to items covering treatment of skin cancer
- a revised structure for regional or field nerve blocks
- widening of the definition of "Intensive Care Unit" to include neonatal intensive care units
- the introduction of a specific item covering radiation oncology planning for brachytherapy, involving subsequent rewording of other brachytherapy items
- minor description amendments to general medical services to clarify the intent of items
- changes to diagnostic imaging services (ultrasound)
- changes to pathology services (including separation of some composite items into more specific groupings)

The changes outlined above are summarised in the following paragraphs and are identified in the Schedule by one or more of the following symbols appearing above the item number where appropriate:-

(a) New service	†
(b) Description of services amended	‡
(c) Fee amended (in addition to general increase)	+
(d) Anaesthetic units amended	@
(e) Item number changed	*

New Items
The following is a list of new items introduced into the Schedule:-

15536	18216	18219	18222	18225	18228	18230	18232	18233	18234	18236	18238	18240	18242
18244	18246	18248	18250	18252	18254	18256	18258	18260	18262	18264	18266	18268	18270
18272	18274	18276	18278	18280	18282	18284	18286	18288	18290	18292	18294	18296	18298
30196	30197	30202	30203	30205	30609	55303	66353	66355	66357	66359	66361	66363	66365
66367	66369	66371	66373	66375	66377	66379	66381	66383	66385	66387	66389	66391	66393
66395	66397	66399	66401	66403									

* Please note that item 18292 was previously MBAC Recommendation 30000(262)

Deleted Items
The following items have been deleted:-

18200	18203	18212	18215	18218	30198	30201	30204	39103	66259
66260	66273	66275	66301	66303	66305	66307	66309	66311	66313

Amended Descriptions
The descriptions of the following items have been amended:-

11303	13815	13824	15518	15521	15524	15527	15530	15533	30195	32004	32005	35300	35303
35306	35309	35312	35315	35637	38497	38500	38503	38640	39000	41731	41764	42653	42656
42659	55028	55029	55030	55031	55032	55033	55034	55035	55036	55037	55038	55039	55040
55041	55042	55043	55044	55045	55048	55049	55050	55051	55052	55053	55054	55056	55057
55300	66201	66231	66317	69207									

Items re-numbered

Old	New
18224	To 18213

Revised Cryotherapy and Serial Curettage Items
For the purposes of items 30196 to 30203 (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven positive for malignancy.

Changes to Diagnostic Imaging
The list of items that can be requested by dental practitioners, prosthodontists and oral and maxillofacial surgeons has been amended (see paragraph DIA.4.8 in the Diagnostic Imaging area of this Book).

Amendments have also been made to the description of some ultrasound items, and the itemisation of transrectal ultrasound has been divided into services rendered by a medical practitioner who did not assess the patient, and those rendered by the medical practitioner who did assess the patient.

Your attention is drawn to Note DIH. in the Diagnostic Imaging area of this Book.

Special Arrangements - Transitional Period
Where an 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 November 1993 and continues beyond that date, the general rule is that the 1 November 1992 level of fees and benefits would apply.

However, in the case of the relevant obstetric items a special rule applies in that the fee and benefit will depend on the date of the actual confinement. If the confinement takes place before 1 November 1993, fees and benefits at the 1 November 1992 level will apply. If the confinement takes place on or after 1 November 1993, fees and benefits at the new (1 November 1993) level will apply.

CONTENTS

GENERAL EXPLANATORY NOTES

Medicare Benefit Arrangements

General Notes for Guidance of Users

GENERAL EXPLANATORY NOTES

MEDICARE BENEFIT ARRANGEMENTS

1. OUTLINE OF SCHEME

1.1 Medicare

1.1.1 The Australian Medicare Program provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Legislation covering the major elements of the Program is contained in the Health Insurance Act 1973 (as amended).

1.1.2 With regard to medical expenses, the basic aim of the Medicare program is to provide:-

- automatic entitlement to benefits in respect of professional services (other than professional services to which the following dot point applies) equal to 85% of the Medicare Benefits Schedule fee, with a maximum payment of $27.70 (indexed annually) by the patient for any one service where the Schedule fee is charged.
- 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), a flat rate of benefit of 75% of the Schedule fee, that is, there is no limit to the maximum amount of gap between the benefit and the Schedule fee; and
- access without direct charge to public hospital accommodation and to treatment by doctors appointed by the hospital.

Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee. For out-of-hospital services the maximum amount of 'gap' (i.e. the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is $247.90 (indexed annually from 1 January). A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

1.1.3 The Health Insurance Commission is responsible for the operation of Medicare and Medicare benefits based on the services and fees contained in this book will be paid only by the Commission (commonly known as Medicare). For details of locations of Medicare offices, see paragraph 1.3 below.

1.1.4 Where an eligible person incurs medical expenses in respect of a professional service Medicare will pay benefits for that service as outlined in these notes. The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or an optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

1.2 Provider Numbers

1.2.1 When a medical practitioner commences private practice, and wishes to assist patients to claim Medicare benefits, or is not in private practice but refers patients to specialists or requests pathology or diagnostic imaging services, a provider number is issued for the required practice location by the Health Insurance Commission following a written request from the practitioner. Provider numbers for different or additional practice locations can be similarly obtained.

1.2.2 Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters in length. The second last character identifies the particular practice location, the last character being a check character.

1.2.3 Registration status information is held against the provider number to ensure correct assessment of Medicare benefits.

1.2.4 If a practitioner wishes Medicare benefit cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to the Health Insurance Commission to do this. There can only be one pay group link for an individual practice location but multiple practitioners and practice locations can be linked to one pay group. Where the pay group involves a third party, signatures of all parties will be required by the Commission before it can be activated. The pay group arrangement can be terminated by a written request from the practitioner, however, the Commission will routinely inform any third party of such a termination. Further information on pay group links may be obtained from the Commission at the addresses below.

1.2.5 It is important that the Health Insurance Commission be notified promptly about any change to practice/s. Failure to notify changes can lead to misdirection of Medicare benefit cheques. Requests for changes to provider particulars should be made in writing to the Manager, Medicare Benefits, at any of the Commission addresses shown below.

1.3 Addresses of the Health Insurance Commission

Postal: Medicare, GPO Box 9822, in the Capital City in each State

NEW SOUTH WALES	VICTORIA	QUEENSLAND
Fairfield Processing Centre Fairfield Chase Cnr Spencer and Smart Streets FAIRFIELD NSW 2165 Tel (02)794 2702 Fax (02)728 1767	Medibank House 460 Bourke Street MELBOURNE VIC 3000 Tel (03)284 3666 Fax (03)284 3899	State Headquarters 444 Queen Street BRISBANE QLD 4000 Tel (07)360 7215 Fax (07)360 7034

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD SA 5063
Tel (08)201 8629
Fax (08)272 6551

WESTERN AUSTRALIA

State Headquarters
Rural & Industries Tower
108 St. George's Terrace
PERTH WA 6000
Tel (09)263 8128
Fax (09)263 8222

TASMANIA

242 Liverpool Street
HOBART TAS 7000
Tel (002)32 1431
Fax (002)32 1499

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG ACT 2901
Tel (06)203 6357
Fax (06)282 5025

NORTHERN TERRITORY

As per New South Wales

2. PATIENT ELIGIBILITY FOR MEDICARE

2.1 Eligible Persons

2.1.1 An "eligible person" means a person who resides legally in Australia and whose stay in Australia is not subject to any limitation as to time, but does not include a foreign diplomat or family (except where eligibility is expressly granted to such persons by the terms of a reciprocal health care agreement). A person covered by a reciprocal health care agreement is eligible for Medicare for services of immediate medical necessity.

2.1.2 The Health Insurance Act gives the Minister discretionary powers to either include or exclude certain persons or categories of persons for eligibility purposes under the Medicare arrangements.

2.1.3 Eligible persons must enrol with Medicare before benefits can be paid.

2.2 Medicare Cards

2.2.1 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare Card which shows the Medicare Card number, the patient identifier number (reference number), the applicant's first given name, initial of second given name, surname, and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to five persons may be listed on the one Medicare card, and up to nine persons may be listed under the one Medicare card number.

2.2.2 Medicare cards issued to eligible visitors to Australia will show the period of eligibility, and will also identify restricted access (if applicable), ie "Visitor RHCA".

2.3 Health Care Expenses Incurred Overseas

2.3.1 Medicare does NOT cover medical or hospital expenses or the cost of medical evacuation incurred outside Australia. It is recommended that Australian residents travelling overseas take out private traveller's or health insurance which offers adequate coverage for the countries to be visited. (See also Reciprocal Health Care Agreements).

2.4 Visitors to Australia and Temporary Residents

2.4.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents, although the Minister has power to extend eligibility to such persons in exceptional circumstances. People visiting Australia specifically for medical or hospital treatment are not eligible for Medicare benefits. (See also Reciprocal Health Care Agreements).

2.4.2 All eligible visitors must enrol with Medicare to receive benefits. A practitioner can determine the eligibility period for visitors by checking the "valid to" date at the bottom right hand corner of the card.

2.5 Reciprocal Health Care Agreements

2.5.1 Visitors from countries with which Australia has signed Reciprocal Health Care Agreements are eligible for benefits for immediately necessary medical services under the Medicare program. Agreements currently in place include United Kingdom, New Zealand, Sweden, Finland and the Netherlands (for length of stay), as well as Malta and Italy (for maximum of six months from date of arrival). Likewise, Australians visiting these countries will be entitled to health care under the particular country's public health scheme for similar periods. Diplomats and their families are only covered by these agreements if specifically mentioned in the agreement. The agreement with New Zealand does not mention diplomats and families and hence this group is excluded from Medicare benefit.

2.5.2 The Agreements provide for immediately necessary medical treatment only, that is, treatment for any episode of ill-health which requires prompt medical attention. Persons who require hospital treatment, and who seek cover under a reciprocal agreement, shall be entitled to admission to public hospitals as public patients only. The agreements do not include pre-arranged or elective treatment, or treatment as a private patient in a public or private hospital.

3. GENERAL PRACTICE

3.1 General Practice Items

3.1.1 Some of the items in the Medicare Benefits Schedule are only available to General Practitioners. For the purposes of the Medicare Benefits Schedule a General Practitioner is a medical practitioner who is:

- Vocationally Registered under section 3F of the Health Insurance Act (see 3.3 below);
- a holder of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participates in, and meets the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Programme; or
- undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP, or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of an equivalent standard.

3.2 Fellows of the RACGP and Trainees in General Practice

3.2.1 A medical practitioner who is seeking recognition as a general practitioner, as a Fellow of the RACGP or as a general practice trainee should apply to the Manager, Medicare Benefits, Health Insurance Commission, at any of the Commission addresses listed in paragraph 1.3.

3.3 Vocational Registration of General Practitioners

Recognition Method

3.3.1 The criteria for registration as a vocationally registered general practitioner are certification from either the Royal Australian College of General Practitioners (RACGP), or a Vocational Registration Eligibility Committee (VREC) or the Vocational Registration Appeal Committee (VRAC), that the practitioner's medical practice is predominantly general practice, and that the practitioner has appropriate training and experience in general practice.

3.3.2 The VRAC will hear appeals from medical practitioners who are refused certification by either the RACGP or a VREC.

3.3.3 The regulations establishing the VRECs and the VRAC require these committees to have regard to the eligibility criteria published by the RACGP and to consider each case on its merits.

3.3.4 The criteria which the RACGP and VRECs/VRAC will use in certifying a practitioner's eligibility are summarised below.

3.3.5 From 1 January 1993, with exceptions as listed in para 3.3.6 below, the only training and experience which the RACGP and VRECs/VRAC will regard as appropriate for eligibility will be the attainment of Fellowship of the RACGP (FRACGP) or an equivalent post-graduate qualification in general practice.

3.3.6 For applications received between 1 January 1993 and 31 December 1994 the RACGP will accept the following training and experience for the purposes of certification:

The medical practitioner is in practice which is predominantly general practice, and

- is a Fellow of the RACGP; or
- holds a Certificate of Satisfactory Completion of Training of the RACGP Family Medicine Programme obtained after 1 January 1993; or
- has completed other postgraduate qualifications and training, approved by the RACGP, of a standard equivalent to that accepted for award of the FRACGP; or
- could have been eligible before 1 January 1993 except that the medical practitioner was not predominantly in General Practice between 1 July 1992 and 31 December 1992.

3.3.7 From 1 January 1995 the only training and experience which the RACGP will regard as appropriate for eligibility will be the attainment of Fellowship of the RACGP, or other postgraduate qualifications and training, approved by the RACGP, of a standard equivalent to that accepted for the award of the FRACGP.

3.3.8 In assessing whether a practitioner's medical practice is predominately general practice, the RACGP and VRECs/VRAC will consider only services eligible for Medicare benefits. To qualify, 50% of this clinical time and services claimed against Medicare must be in general practice as defined. The RACGP and VRECs/VRAC will have regard to whether the practitioner provides a comprehensive primary medical service, including treating a wide range of patients and conditions using a variety of accepted medical skills and techniques, providing services away from the practitioner's surgery on request, for example, home visits and making appropriate provision for the practitioner's patients to have access to after hours medical care.

3.3.9 All enquiries concerning eligibility for registration should be directed to the RACGP at 39 Terry Street, Rozelle, NSW, 2039, or to the VREC in your State c/- GPO Box 9848, (CAPITAL CITY AND POST CODE).

How to Apply for Registration

3.3.10 To be listed on the register, application on the approved form must be made to the RACGP or a VREC for certification of eligibility. The RACGP or the VREC will notify the Health Insurance Commission of the eligibility status of the practitioner and request that eligible practitioners who indicated their wish to be entered on the VR register be placed on the register. Alternatively, eligible practitioners may apply to the Health Insurance Commission at a later date to be placed on the VR register.

3.3.11 The RACGP and State VRECs addresses for the purpose of submission of applications for registration as a vocationally registered general practitioner are:

The Secretary-General
The Royal Australian College of General Practitioners
P O Box 906
ROZELLE NSW 2039

Secretary
Vocational Registration Eligibility Committee
GPO Box 9848
(CAPITAL CITY AND POSTCODE)

3.3.12. Continued vocational registration is dependent upon involvement in appropriate Continuing Medical Education (CME) and Quality Assurance (QA) programs approved by the RACGP, and the practitioner continuing to be predominantly in general practice.
3.2.13 All enquiries regarding the QA and CME requirements should be directed to the RACGP at 39 Terry Street, Rozelle, NSW, 2039.

Removal from Vocational Register
3.3.14 A medical practitioner may at any time request the Managing Director of the Health Insurance Commission to remove his/her name from the Vocational Register of General Practitioners.
3.3.15 Provision also exists for removal of a medical practitioner from the Vocational Register where the RACGP is no longer satisfied that the practitioner should remain on the Register. Examples of reasons for which a practitioner might be removed are:

- the practitioner's medical practice is no longer predominantly general practice;
- the RACGP's minimum requirements for involvement in continuing Medical Education and Quality Assurance programs have not been met by the practitioner;
- where the RACGP is no longer satisfied that the practitioner has appropriate training and experience in general practice (e.g. if certification was made on the basis of false information).

3.3.16 Appeals against removal may be made to the VRAC.

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

4. RECOGNITION AS A SPECIALIST OR CONSULTANT PHYSICIAN

4.1 Recognition Method
4.1.1 A medical practitioner who, having made formal application and paid the prescribed fee, and who -

- is registered as a specialist under State or Territory law; or
- holds a fellowship of a specified specialist College; or
- is considered eligible for recognition as a specialist or consultant physician by a Specialist Recognition Advisory Committee;

may be recognised by the Minister as a specialist or consultant physician for the purposes of the Health Insurance Act.
4.1.2 There is provision for appeal to a Specialist Recognition Appeal Committee by medical practitioners who have not been recommended for recognition as specialists or consultant physicians by an Advisory Committee.
4.1.3 Where a medical practitioner has been recognised as a specialist or consultant physician for the purposes of the Health Insurance Act, Medicare benefits are payable at the appropriate higher rate in respect of certain services rendered by the practitioner in the practice of the recognised specialty, provided (other than in the case of examination by specialist anaesthetists in preparation for anaesthesia - see paragraph 5.3.1) the patient has been referred in accordance with paragraph 5.3.
4.1.4 All enquiries concerning the recognition of specialists and consultant physicians should be directed to State Manager, Commonwealth Department of Health, Housing, Local Government and Community Services at one of the following addresses as appropriate:-

NEW SOUTH WALES

333 Kent Street
SYDNEY NSW 2000
Tel (02)225 3555
Fax (02)262 1411

VICTORIA

2 Lonsdale Street
MELBOURNE VIC 3000
Tel (03)285 8888
Fax (03)285 8585

QUEENSLAND

5th Floor Samuel Griffith Building
340 Adelaide Street
BRISBANE QLD 4000
Tel (07)360 2555
Fax (07)360 2999

SOUTH AUSTRALIA

Commonwealth Centre
55 Currie Street
ADELAIDE SA 5000
Tel (08)237 6111
Fax (08)210 9609

WESTERN AUSTRALIA

Capita Centre
197 St George's Terrace
PERTH WA 6000
Tel (09)426 3444
Fax (09)426 3524

TASMANIA

Montpelier Building
21 Kirksway Place
BATTERY POINT, TAS 7004
Tel (002)21 1411
Fax (002)21 1412

AUSTRALIAN CAPITAL TERRITORY

Alexander Building
Furzer Street
PHILLIP ACT 2606
Tel (06)289 1555
Fax (06)289 8509

NORTHERN TERRITORY

Cascom Centre
13 Scaturchio Street
CASUARINA NT 0800
Tel (089)46 3444
Fax (089)46 3400

5. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

5.1 Purpose

5.1.1 For certain services provided by specialists and consultant physicians the Medicare benefit payable is dependent on acceptable evidence that the service has been provided following referral from another practitioner.

5.1.2 A reference to a referral in this Section does not refer to written requests made for pathology services or diagnostic imaging services.

5.2 What is a Referral

5.2.1 A "referral" is a request to a specialist or a consultant physician for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).

5.2.2 Subject to the exceptions in paragraph 5.2.3 below, for a valid "referral" to take place:

(i) the referring practitioner must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist or consultant physician (but this does not necessarily mean an attendance on the occasion of the referral);

(ii) the instrument of referral must be in writing by way of a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and

(iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

5.2.3 The exceptions to the requirements in paragraph 5.2.2 are that:

(a) sub-paragraphs (i), (ii) and (iii) do not apply to:

- an examination of a patient by a specialist anaesthetist in preparation for the administration of an anaesthetic (Item 17603);

(b) sub-paragraphs (ii) and (iii) do not apply to:

- a referral generated within a hospital, in respect of a private inpatient for a service within that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or to
- an emergency situation where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and

(c) sub-paragraph (iii) does not apply to:

- instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

5.3 Examination by Specialist Anaesthetists

5.3.1 A referral letter or note is not required in the case of Item 17603 - Examination of a patient in preparation for the administration of an anaesthetic. The specialist rate of benefit is payable provided the service is rendered by a specialist anaesthetist. However, for benefits to be payable at the specialist rate for consultations by specialist anaesthetists (other than for a pre-operative examination) a referral is required.

5.4 Who can Refer

5.4.1 Referrals are to be made as follows:

(a) to a recognised consultant physician -

(i) by another medical practitioner; or

(ii) by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service;

(b) to a recognised specialist -

(i) by another medical practitioner; or

(ii) by a registered dental practitioner, where the referral arises out of a dental service; or

(iii) by a registered optometrist where the specialist is an ophthalmologist.

5.4.2 The general practitioner is regarded as the primary source of referrals. Cross referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner.

5.5 Billing

Routine Referrals

5.5.1 In addition to the usual information required to be shown on accounts, receipts or assignment forms (see paragraph 6 of these notes), specialists and consultant physicians must show the following details (unless there are special circumstances as indicated in paragraph 5.5.2):

- name and either practice address or provider number of the referring practitioner;
- date of referral; and
- period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely" should be shown.

Special Circumstances

5.5.2 (i) Lost, stolen or destroyed referrals.

If a referral has been made but the letter or note of referral has been lost, stolen or destroyed, benefits will be payable at the referred rate if the account, receipt or the assignment form shows the name of the referring medical practitioner, the practice address or provider number of the referring practitioner (if either of these are known to the consultant physician or specialist) and the words 'Lost referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate a duplicate or replacement letter of referral must be obtained by the specialist or the consultant physician.

(ii) Emergency situations.

If the referral occurred in an emergency situation, benefit will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Emergency referral'. This provision only applies to the initial attendance. For subsequent attendances to attract Medicare benefits at the referred rate the specialist/consultant physician must obtain a letter of referral.

(iii) Hospital referrals.

• Private Inpatients - Where a referral is generated within a hospital in respect of a private inpatient for a service within that hospital, benefits will be payable at the referred rate if the account, receipt or assignment form is endorsed 'Referral within (name of hospital)' and the patient's hospital records show evidence of the referral (including the referring practitioner's signature). However, in other instances where a medical practitioner within a hospital is involved in referring a patient (eg to a specialist or a consultant physician in private rooms) the normal referral arrangements apply, including the requirement for a referral letter or note and its retention by the specialist or the consultant physician billing for the service.

• Medicare Hospital Patients - Where a public inpatient is treated by a specialist or a consultant physician and on discharge is referred to that same specialist or consultant physician for follow-up or aftercare in private practice because the hospital provides no outpatient facility, a referral letter or note from a medical practitioner at the hospital is required. In such circumstances, the relevant subsequent attendance item should be claimed.

Direct Billing

5.5.3 Direct billing assignment forms should show the same information as detailed above. However, faster processing of the claim will be facilitated where the provider number (rather than the practice address) of the referring practitioner is shown.

5.6 Period for which Referral is Valid

5.6.1 If a referring practitioner wishes that a referral be for a period less than or more than 12 months (eg. 3, 6 or 18 months or valid indefinitely), he/she should indicate this to the specialist or the consultant physician.

5.6.2 The referral is valid for the period specified (or 12 months where not otherwise indicated) from the date of the specialist's or the consultant physician's first service.

5.6.3 The purpose in permitting a referral for longer than 12 months is to obviate the necessity for a chronically ill patient, who is under the continuing care and management of a specialist or a consultant physician for a specific condition(s), to obtain a new referral at the end of each 12 months.

5.7 Definition of a Single Course of Treatment

5.7.1 A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also

includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary; such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

5.7.2 The presentation of an unrelated illness, requiring the referral of the patient to the specialist's or the consultant physician's care would initiate a new course of treatment in which case a new referral would be required.

5.7.3 The receipt by a specialist or consultant physician of a new referral following the expiration of a previous referral for the same condition(s) does not necessarily indicate the commencement of a new course of treatment involving the itemisation of an initial consultation. In the continuing management/treatment situation the new referral is to facilitate the payment of benefits at the specialist or the consultant physician referred rates rather than the unreferred rates.

5.7.4 However, where the referring practitioner:

(a) deems it necessary for the patient's condition to be reviewed; and

(b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and

(c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

the attendance following the new referral initiates a new course of treatment for which Medicare benefit would be payable at the initial consultation rates.

5.8 Retention of Referral Letters

5.8.1 The prima facie evidence that a valid referral exists is the provision of the referral particulars on the specialist's or the consultant physician's account.

5.8.2 A specialist or a consultant physician is required to retain the instrument of referral (and a hospital is required to retain the patient's hospital records which show evidence of a referral) for 18 months from the date when the service was rendered.

5.8.3 A specialist or a consultant physician is required, if requested by the Managing Director of the Health Insurance Commission, to produce to a Medical Adviser, who is an officer of the Commission, the instrument of referral as soon as practicable, but in any case no later than the end of the day after the day on which the request is made. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

5.9 Attendance for Issuing of a Referral

5.9.1 Medicare benefit is attracted for an attendance on a patient even where the attendance is solely for the purpose of issuing a referral letter or note. However, if a medical practitioner issues a referral without an attendance on the patient, no benefit is payable for any charge raised for issuing the referral.

5.10 Locum-tenens Arrangements

5.10.1 It should be noted that where a non-specialist medical practitioner acts as a locum-tenens for a specialist or consultant physician, or where a specialist acts as a locum-tenens for a consultant physician, Medicare benefit is only payable at the level appropriate for the particular locum-tenens, eg, general practitioner level for a general practitioner locum-tenens and specialist level for a referred service rendered by a specialist locum tenens.

5.10.2 Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice i.e. referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral.

5.11 Self Referral

5.11.1 Medical practitioners may refer themselves to consultant physicians and specialists and Medicare benefits are payable at referred rates.

5.12 Referrals by Dentists or Optometrists

5.12.1 For Medicare benefit purposes, a referral may be made to -

(i) a recognised specialist:

(a) by a registered dental practitioner, where the referral arises out of a dental service; or

(b) by a registered optometrist where the specialist is an ophthalmologist; or

(ii)a consultant physician, by an approved dental practitioner (oral surgeon), where the referral arises out of a dental service.

5.12.2 In any other circumstances (i.e. a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is <u>not</u> a valid referral. Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

5.12.3 Registered dentists and registered optometrists may refer themselves to specialists in accordance with the criteria above, and Medicare benefits are payable at the levels which apply to their referred patients.

6. BILLING PROCEDURES

6.1 Itemised Accounts

6.1.1 Where the doctor bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

6.1.2 Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

(i) patient's name;

(ii) the date on which the professional service was rendered;

(iii) 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;

(iv) the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with the Health Insurance Commission, the provider number used should be that which is applicable to the practice location at or from which the service was given);

(v) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-

- for services in Groups A1 to A10, D1, T1, T4 to T9 of the General Medical Services, Groups O1 to O7 (Oral and Maxillo Facial services), and Group P9 of Pathology - where the person claiming payment is NOT the person who rendered the service;
- for services in Groups D2, T2, T3, I2, I3, and I5 - for every service;

(vi) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group P9 of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;

(vii) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and

(viii) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number in respect of that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

(NOTE: If the information required to be recorded on accounts, receipts or assignment of benefit forms is included by an employee of the practitioner, the practitioner claiming payment for the service bears responsibility for the accuracy and completeness of the information).

6.1.3 Practitioners should note that payment of claims could be delayed or disallowed where it is not possible from account details to clearly identify the service as one which qualifies for Medicare benefits, or the practitioner as a registered medical practitioner at the address the service was rendered. Practitioners are therefore encouraged to provide as much detail as possible on their accounts, including Medicare Benefits Schedule item number and provider number.

6.2 Claiming of Benefits

6.2.1 The patient, upon receipt of a doctor's account, has two courses open for paying the account and receiving benefits.

6.3 Paid Accounts

6.3.1 The patient may pay the account and subsequently present the account, supporting receipt and a covering Medicare claim form to Medicare for assessment and payment of Medicare benefit.

6.4 Unpaid Accounts

6.4.1 Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the doctor.

6.4.2 It will be the patient's responsibility to forward the cheque to the doctor and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to medical practitioners or to patients at a doctor's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the patient's normal address.

6.4.3 When issuing a receipt to a patient in respect of an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the medical practitioner should indicate on the receipt that a "Medicare" cheque for $..... was involved in the payment of the account.

6.5 Assignment of Benefit (Direct-Billing) Arrangements

6.5.1 Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a medical practitioner direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- the patient's Medicare number must be quoted on all direct-bill forms for that patient;
- the basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare Card;
- the forms include information required by Regulations under Section 19(6) of the Health Insurance Act;
- the doctor must cause the particulars relating to the professional service to be set out on the assignment form, before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it;
- where a patient is unable to sign the assignment form, the signature of the patient's parent, guardian or other responsible person (other than the doctor, doctor's staff, hospital proprietor, hospital staff, nursing home proprietor or nursing home staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed 'Practitioner's Use' or on the back of the assignment form, an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific. .

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).

6.6 Use of Medicare Cards in Direct Billing

6.6.1 The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.

6.6.2 The patient details can, of course, be entered on the direct-bill forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

6.6.3 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.

6.6.4 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

6.6.5 It is important for the practitioner to check the eligibility of patients to Medicare benefits by reference to the card, as enrolees have entitlement limited to the date shown on the card and some enrolees, e.g. certain visitors to Australia, have restricted access to Medicare (see paragraphs 2.2 and 2.5).

6.7 Assignment of Benefit Forms

6.7.1 To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Health Insurance Commission.

(a) Form DB2. This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy. This form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.

(b) Form DB4. It is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

(c) Form DB3. It is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.

(d) Form DB5. This is a continuous stationery form for pathology which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an "offer to assign" (Form DB2, DB3 or DB4) or other form approved by the Health Insurance Commission for that purpose.

6.8 The Claim for Assigned Benefits (Form DB1, DB1H)

6.8.1 Practitioners who accept assigned benefits must claim on Medicare using either Claim for Assigned Benefits form DB1 or DB1H. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than Medicare hospital patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for

use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.
6.8.2 Each claim form must be accompanied by the assignment forms to which the claim relates.
6.8.3 The DB1 and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

6.9 Direct-Bill Stationery
6.9.1 Medical practitioners wishing to direct-bill may obtain direct- bill stationery by contacting any Medicare office. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

6.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits
6.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.
6.10.2 Provision exists whereby in certain circumstances (e.g. hardship cases, third party workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

7. PROVISION FOR REVIEW AND INQUIRY (GENERAL MEDICAL SERVICES) (See also Category 5 for Diagnostic Imaging Arrangements and Category 6 for Pathology Arrangements)

7.1 Medical Services Committees of Inquiry (MSCI)
7.1.1 MSCI's were established as a means of identifying the provision of excessive services by practitioners for which Medicare benefits have been paid or are payable.
7.1.2 MSCI's may inquire and report on references from the Minister concerning the rendering of excessive medical services. (see paragraph 8.2 below)
7.1.3 Excessive services are defined in the Act as being services in respect of which Medicare benefits have become or may become payable, that are not reasonably necessary for the adequate medical care of the patient concerned. (See Category 6 in respect of initiation of excessive pathology services).
7.1.4 MSCI's consist of five members all of whom are medical practitioners.

7.2 Medical Services Review Tribunal (MSRT)
7.2.1 The functions of the Tribunal are to consider requests for review of Ministerial Determinations made under section 106 of the Health Insurance Act (ie. Determinations arising out of recommendations of Medical Services Committees of Inquiry).
7.2.2 MSRT may affirm, set aside or vary these Determinations.
7.2.3 The MSRT's consist of a President, who is or has been the holder of a judicial office or is a legal practitioner of the High Court or Supreme Court of a State or Territory of not less than five years standing, and two other members, both of whom are required to be medical practitioners.

7.3 Medicare Benefits Advisory Committee (MBAC)
7.3.1 This Committee is established under the provisions of Section 66 of the Health Insurance Act. Membership of the Committee consists of representatives of the medical profession and the Commonwealth Government. There are eight members on the Committee, five of whom must be medical practitioners.
7.3.2 The primary function of the Committee is to consider claims made under Section 11 of the Health Insurance Act for higher Schedule fees and benefits for medical services considered to be of undue length and complexity (see paragraph 9.2). It also considers benefits for services not listed in the Medicare Benefits Schedule (see paragraph 10).

7.4 Medicare Participation Review Committee (MPRC)
7.4.1 The Medicare Participation Review Committees determine what administrative action should be taken against a practitioner who has been successfully prosecuted for medifraud.
7.4.2 The Committees have a discretionary range of options from taking no further administrative action against the practitioner to counselling and reprimand and full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

7.5 Medicare Benefits Consultative Committee (MBCC)
7.5.1 The MBCC is an informal advisory committee established by agreement between the Minister and the Australian Medical Association. The Committee consists of representatives of the Department, the Health Insurance Commission, the Australian Medical Association and relevant craft groups of the medical profession.
7.5.2 The major function undertaken by the Committee is the review of particular services or groups of services within the Medicare Benefits Schedule, including consideration of appropriate fee levels.

7.6 Pathology Services Table Committee (PSTC)

7.6.1 This informal Committee is established under Section 136 of the National Health Act 1953. It consists of five representatives from the interested professions and five from the Commonwealth.

7.6.2 The Committee's primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table including the level of fees.

7.6.3 The Committee also considers claims and appeals made under Sections 11 and 12 of the Health Insurance Act 1973 for higher Schedule fees and benefits for pathology services considered to be of unusual length or complexity. (see paragraph PM. of the Category 6 Explanatory Notes).

8. PENALTIES AND LIABILITIES

8.1 Penalties

8.1.1 Penalties of up to $10,000 or imprisonment for up to five years, or both, may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a court (on or after 22 February 1986) shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

8.1.2 A penalty of up to $1000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the necessary details having been entered on the form before signature or who fails to cause a copy of the completed form to be given to the patient.

8.2 Provision of Excessive Services

8.2.1 Medicare benefits are only payable in respect of professional services listed in the Schedule to the Health Insurance Act and then, only when those services are reasonably necessary for the adequate medical care of the patient concerned.

8.2.2 It is recognised that medical practitioners will sometimes be called upon to provide services which cannot be considered as being medically necessary. Accounts for these services should not be itemised as attracting Medicare benefits. The fee charged for such services is a private matter between the practitioner and the patient.

8.2.3 The Health Insurance Commission is required to investigate where there are reasonable grounds to suspect that a practitioner may have rendered excessive medical services. The Commission has a computerised monitoring program which records claims for Medicare benefits for services provided by every practitioner. Medical practitioners, employed by the Commission as medical advisers, may seek the opportunity to discuss with doctors claims submitted for payment of Medicare benefits for services rendered by the doctor. Should the Commission identify a situation where it strongly suspects that claimed medical services are excessive, it is required to refer the matter to the Minister (or his delegate) for consideration of a referral to a Medical Services Committee of Inquiry. This Committee may then seek clarification from the doctor as to the medical necessity of those services so referred.

8.2.4 If a Medical Services Committee of Inquiry is satisfied that excessive services have been provided it may make one or more of the following recommendations to the Minister:-

- that the practitioner be reprimanded;
- that the practitioner be counselled;
- that the practitioner reimburse the Commonwealth an amount equal to the Medicare benefits paid in respect of services identified as excessive. Where the Minister agrees with such recommendation the practitioner/person is liable to pay by way of penalty to the Commonwealth, in addition to the Medicare benefit required to be paid, a penalty being an amount equal to the amount of Medicare benefit repaid. If a practitioner has on a second or subsequent occasion been required to pay such a penalty then the practitioner will be referred to a Medicare Participation Review Committee which may disqualify a medical practitioner from the Medicare arrangements. It should be noted that under the provisions of the Act:-

  a practitioner can be required to reimburse the Commonwealth for part of Medicare benefits paid, when a practitioner has been paid benefit for a particular service he/she has claimed to have rendered and a Committee is of the opinion that a less costly service would have been satisfactory eg. a long consultation claimed and paid for in lieu of a standard consultation.

8.2.5 The Act also provides for the Minister's decision on the recommendation to be reviewed by the Medical Services Review Tribunal which is established under the Health Insurance Act for this specific purpose.

8.2.6 Where a determination becomes effective, the Act requires the details of the determination to be tabled in Parliament and states that they may also be published in the Commonwealth of Australia Gazette.

GENERAL NOTES FOR GUIDANCE OF USERS

9. SCHEDULE FEES AND MEDICARE BENEFITS

9.1 Schedule Fees and Medicare Benefits

9.1.1 Medicare benefits are based on fees determined for each medical service, with uniform fees for each service in each State. The fee is referred to in these notes as the "Schedule fee". As a general rule Schedule fees are adjusted on an annual basis. The current Schedule fees came into operation on 1 November 1993. Adjustments to Schedule fees are rounded in accordance with the rounding rules set out below. To avoid perpetuating any anomalies caused by the application of the rounding principles, fee increases are applied to the unrounded fees of the previous year.

Rounding Rules:-

- After the application of fee increases, the unrounded Schedule fees are rounded to the nearest 5 cents.
- Where adjusted fees fall exactly on the division between rounding up and rounding down, the fees are rounded down (e.g. a calculated fee of $20.025000 rounds to $20.00 and a calculated fee of $20.025001 to $20.05)

9.1.2 In relation to calculation of fees for derived fee items in the Schedule, where the amount calculated is not a multiple of 5 cents, it is rounded to the next higher amount that is a multiple of 5 cents.

9.1.3 The Schedule fee and Medicare benefit levels for the medical services contained in the Schedule are located with the item descriptions. Where appropriate, the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the benefit payable for any service exceed the amount of the fee actually charged for that service. There are presently two levels of Medicare benefit payable, that is :-

(i) 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), the level of Medicare benefit is 75% of the Schedule fee for each item with no maximum patient gap between the Medicare benefit and the Schedule fee. The Health Insurance Regulations provide that medical practitioners must indicate on their accounts, etc, where a medical service is rendered in these circumstances. This requirement will be met by placing the word "admitted patient" immediately preceding the description of each service or, alternatively, where an item number is used, by placing an asterisk "*" directly after the item number for each service.

(ii) for all other medical services, the Medicare benefit is 85% of the Schedule fee, or the Schedule fee less $27.70 (indexed annually) whichever is the greater.

9.1.4 Public hospital treatment is available without direct charge to public patients.

9.1.5 A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, but prior to admission or subsequent to discharge, will attract benefits at the 85% level not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by paragraph 9.1.3 (i) above) attract benefits at the 85% level.

9.1.6 The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to the comprehensive obstetric items (ie. 16506, 16507, 16510, 16513, 16516 and 16517) benefits would be attracted at the 75% level where the confinement takes place in hospital.

9.1.7 Pathology tests performed after discharge from hospital on bodily specimens taken during hospitalisation also attract the 75% level of benefits.

9.1.8 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (i.e., the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level.

9.1.9 Where it can be established that payments of $247.90 (indexed annually from 1 January) have been made by a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee.

9.2 Service of Unusual Length or Complexity

9.2.1 The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered. Section 11 of the Health Insurance Act provides that the claimant for Medicare benefits may apply to the Health Insurance Commission for higher benefits by the fixation of a higher fee, where a medical practitioner considers that special consideration is warranted because of the "unusual length or complexity" of the service in the particular case. The term "unusual length or complexity" in this context refers to instances where these factors significantly exceed those usually encountered for the service listed in the Schedule. (see paragraph PM. of the Category 6 Explanatory Notes in relation to pathology services).

9.2.2 Any such application for a higher fee under Section 11 of the Health Insurance Act should be made to the Health Insurance Commission and should be supported by a statement by the medical practitioner indicating in detail those unusual features which are the basis for the claim for a higher fee. The doctor rendering the service should advise the patient to forward this statement with the claim form and account to the relevant Medicare office. Where the doctor direct- bills the Health Insurance Commission, his statement should be attached to the assignment form.

9.2.3 To reduce delays and to facilitate consideration of such an application, it is essential that medical practitioners give precise details of those unusual features of length of time, complexity and technical difficulty which might warrant approval of a higher fee. The statement should include:

- the time taken;
- the factors which caused the undue length of time taken;
- special difficulties or complexities encountered beyond those which would normally be expected in the procedure;
- other significant factors, such as the general condition of the patient, anaesthetic problems and need for resuscitation.

9.2.4 Generally, such applications are referred for consideration by the Medicare Benefits Advisory Committee which may recommend the payment of a higher benefit by approval of a fee higher than the Schedule fee in the particular case. In reporting on such applications, the Committee may state the principles it followed in fixing the amount of any increased fee and benefit for the service which was the subject of the application.

9.2.5 Subsequent applications to which the principles determined by the Committee can be applied, may be dealt with by the Health Insurance Commission in accordance with those principles, without further reference to the Committee.

9.2.6 Where the Health Insurance Commission notifies a claimant of a decision based on the application of principles determined by the Committee, that person may, within one month after receipt of notification of the Health Insurance Commission's decision in the matter of an increased fee, appeal to the Minister to have the decision reviewed.

9.2.7 The Minister will forward the appeal to the Medicare Benefits Advisory Committee for consideration and recommendation. The Minister shall, in accordance with the recommendation of the Committee, either allow or dismiss the appeal and direct the Health Insurance Commission to give effect to the recommendation of the Committee. The Minister will also notify the appellant in writing of the decision regarding the appeal.

9.2.8 The Medicare Benefits Advisory Committee cannot consider cases involving proposed surgery. However, the Health Insurance Commission is prepared to offer an opinion on whether proposed surgery might attract Medicare benefits but such opinions are restricted to proposed surgery involving augmentation mammaplasty, meloplasty or blepharoplasty (see Category 3 Explanatory Notes regarding these procedures).

10. SERVICES NOT LISTED IN THE SCHEDULE (See also paragraph 13.2.1)

10.1 Services not Listed in Schedule

10.1.1 Instances may arise where a particular medical service rendered by a medical practitioner is not listed in the Schedule or in the index to the Schedule. To enable Medicare benefits to be paid in respect of professional services rendered which are not covered by specific items in the Schedule, six non-specific items are included in the Medicare Benefits Schedule i.e., Item Nos. 17971, 30000, 52001, 60700 and 61501/61502.

10.1.2 It is realised that the Schedule fees listed for these items will generally be regarded as inadequate for the services which may be claimed under these items. However, it is intended that an appropriate Schedule fee for each service itemised under the "non specific" items will be determined by the Medicare Benefits Advisory Committee under Section 11 of the Health Insurance Act. For an explanation of the provisions of Section 11 see paragraph 9.2.

10.1.3 To facilitate the Committee's consideration of such cases, medical practitioners are requested to provide as much information as possible in respect of the particular service. Cases of this nature should be referred to the local office of the Health Insurance Commission for transmission to the Medicare Benefits Advisory Committee for consideration.

10.1.4 A number of recommendations which have already been made by the Medicare Benefits Advisory Committee in relation to services not specifically covered in the Schedule are listed at the end of Category 3. These services have been allocated specific reference numbers in parentheses. Practitioners must not use other item numbers on their accounts in respect of procedures that are not listed in the Schedule.

10.2 Service Differs from that Described in Schedule Item

10.2.1 From time to time practitioners discover that services which they are carrying out do not fit precisely within the definitions of items contained in the Schedule. It is emphasised that under these circumstances practitioners should not incorrectly describe the service they have performed, for example by choosing the item number which most nearly fits the service.

10.2.2 The procedures to be followed in these circumstances are outlined in paragraph 10.1 above. Enquiries concerning services not listed or on matters of interpretation should be directed to the appropriate office of the Health Insurance Commission. Postal addresses are listed in paragraph 1.3 of these notes. Telephone enquiries should be directed to the numbers below; these numbers are reserved for enquiries concerning the Schedule:

NSW - 02 5612212
VIC - 03 2843661
QLD - 07 3607215
SA - 08 2018629
WA - 09 2638126 or 2638127
TAS - 002 321400
ACT - 06 2036360
NT - use New South Wales enquiry number.

10.3 Ministerial Determinations

10.3.1 Section 3C of the Health Insurance Act empowers the Minister to determine an item and Schedule fee (for the purposes of the Medicare benefits arrangements) for a service not included in the health insurance legislation. This arrangement is particularly useful in facilitating payment of benefits for newly developed techniques where close monitoring is desirable and where quick remedial action may become necessary. Services which have been so determined by the Minister are located in their relevant Groups in the Schedule but are identified by the notation "(Ministerial Determination)".

11. SERVICES ATTRACTING MEDICARE BENEFITS

11.1 Professional Services

11.1.1 Professional services which attract Medicare benefits include medical services rendered by or on behalf of a medical practitioner. Medical services which may be rendered "on behalf of" a medical practitioner include services where a portion of the service is performed by a technician employed by or, in accordance with accepted medical practice, acting under the supervision of the medical practitioner.

11.1.2 The health insurance regulations specify that the following medical services will attract benefits only if they have been personally performed by a medical practitioner on not more than one patient on the one occasion (i.e. two or more patients cannot be attended simultaneously although patients may be seen consecutively), other than an attendance on a person in the course of a group session (i.e. Items 170-172). The requirement of "personal performance" is met whether or not assistance is provided in the performance of the service according to accepted medical standards:

(a) All Category 1 (Professional Attendances) items (except 154-156 and 170-172),
(b) Each of the following items in Group D1 (Miscellaneous Diagnostic):- 11012, 11015, 11018, 11021, 11212, 11303, 11500, 11600, 11627, 11630, 11701, 11712, 11921, 12000, 12003, 12100, 12103, 12106, 12109, 12112 and 12115,
(c) All Group T1 (Miscellaneous Therapeutic) items (except 13200-13206, 13212-13221, 13915-13948, 14050 and 14053),
(d) All Group T3 (Therapeutic Nuclear Medicine) items,
(e) All Group T4 (Obstetrics) items (except 16555),
(f) All Group T5 (Assistance in Administration of an Anaesthetic) items,
(g) All Group T6 (Anaesthetics) items,
(h) All Group T7 (Regional or Field Nerve Block) items,
(i) All Group T8 (Operations) items,
(j) All Group T9 (Assistance at Operations) items.

11.1.3 For the group psychotherapy and family group therapy services covered by Items 154, 155, 156, 170, 171 and 172, benefits are payable only if the services have been conducted by the medical practitioner himself.

11.1.4 Medicare benefits are not payable for these group items or any of the items listed in (a)-(j) above when the service is rendered by a medical practitioner employed by the proprietor of a hospital, not being a private hospital, other than when the practitioner is exercising his or her right of private practice or is performing a medical service outside the hospital. For example, benefits are not attracted when a hospital intern or registrar performs a service at the request of a staff specialist or visiting medical officer.

11.2 Services Rendered "On Behalf Of" Medical Practitioners

11.2.1 Medical services not included in the above list (i.e. the items in Categories 5 and 6 of the Schedule together with those items in Categories 2 and 3 not specified above) continue to attract Medicare benefits if the service is rendered by:-

(i) a medical practitioner;
(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.

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

12. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

12.1 Services Not Attracting Benefits

12.1.1 Medicare benefits are not payable for telephone consultations, for the issue of repeat prescriptions when the patient is not in attendance, and for group attendances (other than group attendances covered by Items 154, 155, 156, 170, 171 and 172) such as counselling, health education, weight reduction or fitness.

12.1.2 There are other services which are not regarded as being 'medical services' for the purposes of the payment of Medicare benefits. These are services performed for cosmetic reasons, such as face lifts, eye-lid reduction, hair transplants (except in certain circumstances), etc. Certain other services such as manipulations performed by physiotherapists do not qualify for Medicare benefit even though they may be done on the advice of a medical practitioner.

12.2 Where Medicare Benefits are not Payable

12.2.1 Medicare benefits are not payable in respect of a professional service in the following circumstances -

(i) where the medical expenses for the service are paid or payable to a recognised (public) hospital;

(ii) where the medical expenses for the service are wholly payable by way of compensation or damages under a State or Commonwealth or Territorial law or under a legal claim. However, where medical expenses are only partly recoverable in such cases, an appropriate portion of Medicare benefit is payable;

(iii) where the service is a medical examination for the purposes of - life insurance, superannuation or provident account scheme, or admission to membership of a friendly society;

(iv) where the service was rendered in the course of the carrying out of mass immunisation.

12.2.2 Unless the Minister otherwise directs, Medicare benefit is not payable in respect of a professional service where:-

(a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory;

(b) the medical expenses were incurred by the employer of the person to whom the service was rendered;

(c) the person to whom that service was rendered was employed in an industrial undertaking and that service was rendered to him for purposes connected with the operation of that undertaking; or

(d) the service was a health screening service (see para 12.3 below).

12.2.3 The legislation empowers the Minister to make regulations to preclude the payment of Medicare benefits for professional services rendered in prescribed circumstances. Such regulations, however, may only be made in accordance with a recommendation made by the Medicare Benefits Advisory Committee (other than pathology services).

12.2.4 Regulations are currently in force to preclude the payment of Medicare benefits in the following circumstances:-

(a) professional services rendered in relation to the provision of chelation therapy (that is to say the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) otherwise than for the treatment of heavy-metal poisoning;

(b) professional services rendered in association with the injection of human chorionic gonadotrophin in the management of obesity;

(c) professional services rendered in relation to the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;

(d) professional services rendered in relation to the use of computerised tomography scanning for the purposes of measuring bone mineral density for osteoporosis assessment;

(e) professional services rendered for the purpose of, or in relation to, the removal of tattoos; and

(f) professional services rendered for the purposes of, or in relation to:

(i) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or

(ii) the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;

if the services are rendered to an inpatient of a hospital.

12.3 Health Screening Services

12.3.1 Unless the Minister otherwise directs Medicare benefits are not payable for health screening services.

12.3.2 A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as - multiphasic health screening; mammography screening (except as provided for in Items 59300/59303); testing of fitness to undergo physical training programs, vocational activities or weight reduction programs; compulsory examinations and tests to obtain a flying, commercial driving or other licence, entrance to schools and other educational facilities, for travel requirements and for the purposes of legal proceedings; compulsory examinations to determine eligibility for social security pensions and allowances; compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

12.3.3 Ministerial directions have been issued in respect of the following categories of health screening services that enable Medicare benefits to be payable:-

- a medical examination or a test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain his/her state of health. In such cases benefits would be payable for the attendance and such tests which would be considered reasonably necessary according to the circumstances of the patient such as age, physical condition, past personal and family history. Examples would be Papanicolaou test in a woman (see para. 12.3.4), blood lipid estimation where a person has a family history of lipid disorder. However, it would not be accepted that a routine check up would necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- medical examinations for reason of age or medical condition, for drivers to obtain or renew a licence to drive a private motor vehicle;
- medical examinations to obtain a certificate of hearing disability required for sales tax exemption for a television decoding device;
- a medical examination provided to an unemployed person at the request of a person to whom the unemployed person has applied for employment;
- a medical examination of, and/or the collection of blood for testing from, persons occupationally exposed to

sexual transmission of disease where the purpose of such an examination or collection is the collection of specimens for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed, (one examination/collection per person per week). Benefits are not attracted in respect of pathology tests resulting from such examination/collection;

- a medical examination to adopt or foster children.

12.3.4 The agreed National Policy on screening for the Prevention of Cervical Cancer, as endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, the Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council, is as follows:

- an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one or two years after first sexual intercourse, whichever is later;
- cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

Note: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph PP.2 of Pathology Services Explanatory Notes in Category 6).

12.4 Services Rendered to a Doctor's Dependants, Partner, or Partner's Dependants

12.4.1 Generally, Medicare benefits are not payable in respect of professional services rendered by a medical practitioner to dependants or partners or a partner's dependants. There can be no medical expense for which Medicare benefits will apply unless a legally enforceable debt is incurred. In such a case, the matter should be referred to the Health Insurance Commission for assessment.

12.5 Workers' Compensation, Third Party Insurance, Damages, etc.

12.5.1 Where the medical expenses for a professional service are wholly covered by way of compensation or damages under a State or Commonwealth or Territorial law, Medicare benefit is not payable in respect of that service.

12.5.2 Where the medical expenses for a service to a person are only partly covered by such compensation etc., Medicare benefits may be paid in respect of that portion of the expense for which the person was not compensated.

12.5.3 Where a settlement has been made and the Minister (or delegate) determines that the settlement has had regard to any medical expenses incurred or likely to be incurred, the Minister (or delegate) may determine that the whole or a specified part of the settlement relates to medical expenses.

12.5.4 Where a claim is made for Medicare benefits and it appears to the Minister (or delegate) that the service may be subject to a claim for compensation or damages, the Minister (or delegate) may direct that no benefit be paid but that there be a provisional payment made of an amount equal to whatever part of the benefit is considered appropriate. If the claimant subsequently receives a compensation or damages payment in respect of the medical expenses, he/she will be required to refund all or part of the provisional payment made, and an undertaking must be given to this effect.

13. INTERPRETATION OF THE SCHEDULE - GENERAL NOTES

13.1 Principles of Interpretation

13.1.1 Each professional service listed in the Schedule is a complete medical service in itself. However, it may also form part of a more comprehensive service covered by another item, in which case the benefit provided for the latter service covers the former as well. For example, benefit is not payable for a bronchoscopy (Schedule Item 41889) where a foreign body is removed from the bronchus (Schedule Item 41895) since the bronchoscopy is an integral part of the removal operation.

13.1.2 Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. This may be instanced by the case in which a radiographic examination is partly completed by one medical practitioner and finalised by another, the only benefit payable being that for the total examination. Another example is where aftercare is carried out by other than the practitioner who performed the operation. The fee for the operation also covers any consequential aftercare and only the one benefit is payable.

13.1.3 Where separate services covered by individual items in the Schedule are rendered by different medical practitioners the individual items apply. For example, if antenatal care is provided by one medical practitioner and the confinement and postnatal care are provided by another medical practitioner, the benefits for the first practitioner's services are payable under Item 16500 or 16503 while benefits for the latter services are payable under Item 16506 or 16507. However, where a medical practitioner who has provided antenatal care for a patient finds it necessary to call in a specialist during the confinement, benefit is payable under Item 16513 as well as under Item 16510.

13.2 Services Attracting Benefits on an Attendance Basis

13.2.1 There are some services which are not listed in the Schedule because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. These services are identified in the indexes to this Book.

13.3 Consultation and Procedures Rendered at the One Attendance

13.3.1 Where there are rendered, during the course of a single attendance, a consultation (under Category 1 of the Medicare Benefits Schedule) and another medical service (under any other Category of the Schedule), benefits are payable subject to certain exceptions, for both the consultation and the other service. Medicare benefits are not payable for the consultation in addition to the following items rendered on the same occasion:-

(i) items with descriptions qualified by the words

(a) "Each Attendance...," "At an Attendance" or "Attendance at which," e.g. Items *15000, 15003, 15006, 15009, 15012, 15100, 15103, 15106, 15109, 15112, 15115, 15203, 15204, 15207, 15208, 15211, 15214, 15348, 15357, 47471, 47681, 47703, 49351, 49878;
(* see paragraph T2.1.2 of Category 3 - Radiation Oncology Explanatory Notes in relation to radiotherapy)

(b) "including all related (or associated) attendances" Item 16510, 16564, 16567, 16570, 16573; and

(c) "including associated consultation" Items 153, 154, 155, 156, 173, 13112, 14050, 14053, 30000, 30003, 30006, 30009, 30010, 30013, 30014, 30213, 32500, 35554, 41674, 41704, 42677;

(ii) those items in Group T4 of the Schedule which cover or include a component for antenatal or postnatal care, Items 16503, 16506, 16507, 16513, 16516, 16517, 16520;

(iii) those items in the Schedule which provide separate benefit for special services for the treatment of obstetrical complications, Items 16523, 16526, 16529, 16532, 16542;

(iv) those items in the Schedule where the attendance is an integral part of the service, Items 13100, 13103; and

(v) all items in Groups T5, T6 and T9 of the Schedule.

13.3.2 Where a service listed in paragraph 13.3.1, sub-paragraph (i)(a) is performed in conjunction with a consultation, benefit is payable for either the consultation or the service but not for both. For those services covered by sub-paragraphs (i)(b), (i)(c), (ii), (iii), (iv) and (v) above, benefits are payable only for the procedure specified in the item, that is, benefits are not payable under any item in Category 1 of the Schedule. However, in the case of radiotherapy treatment, benefits are payable for both the radiotherapy and an initial referred consultation.

13.3.3 In cases where the level of benefit for an attendance depends upon consultation time (e.g., attendance by consultant physicians in psychiatry), the time spent in carrying out a procedure, which is covered by another item in the Schedule, must not be included in the consultation time.

13.3.4 Medical practitioners should ensure that a fee for a consultation is charged only when a consultation actually takes place. It is not expected that a consultation fee will be charged on every occasion a procedure is performed.

13.4 Aggregate Items

13.4.1 The Schedule includes a number of items which apply only in conjunction with another specified service listed in the Schedule. These items provide for the application of a fixed loading or factor to the fee and benefit for the service with which they are rendered. Item 15003 - Superficial radiotherapy of two or more Fields - is an example.

13.4.2 When these particular procedures are rendered in conjunction, the legislation provides for the procedures to be regarded as one service and for a single patient gap to apply. The Schedule fee for the service will be ascertained in accordance with the particular rules shown in the relevant items.

13.4.3 Examples of the services to which this aggregation principle applies are Items 15003, 15009, 15103, 15109, 15115, 15214, 17977, 59103, 59739, 60300, 61322, 61323 and 61490

GENERAL MEDICAL SERVICES

CATEGORIES 1, 2 and 3

PROFESSIONAL ATTENDANCES

CATEGORY 1

CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

A.1 Personal Attendance by Practitioner

A.1.1 The personal attendance of the medical practitioner upon the patient is necessary before a "consultation" may be regarded as a professional attendance. In itemising a consultation covered by an item which refers to a period of time, only that time during which a patient is receiving active attention should be counted. Periods such as when a patient is resting between blood pressure readings, waiting for pupils to dilate after the instillation of a mydriatic, or receiving short wave therapy etc., should not be included in the time of the consultation. Similarly, the time taken by a doctor to travel to a patient's home should not be taken into consideration in the determination of the length of the consultation. While the doctor is free to charge a fee for "travelling time" when patients are seen away from the surgery, benefits are payable only in respect of the time a patient is receiving active attention.

A.2 Services Not Attracting Medicare Benefits

A.2.1 Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death or cremation certificates, counselling of relatives (Note - Items 157, 158 and 159 are not counselling services), group attendances (other than group attendances covered by Items 154, 155, 156, 170, 171 and 172) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

A.3 Multiple Attendances

A.3.1 Payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner provided the subsequent attendances are not a continuation of the initial or earlier attendances.

A.3.2 However, there should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

A.3.3 Where two or more attendances are made on the one day by the same medical practitioner the time of each attendance should be stated on the account (e.g., 10.30 a.m. and 3.15 p.m.) in order to assist in the assessment of benefits.

A.3.4 In some circumstances a subsequent attendance on the same day does in fact constitute a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then an hour or so later eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. A further example is in the case of skin sensitivity testing.

A.4 Attendances by General Practitioners (Items 3-51)

A.4.1 Items 3 to 51 relate specifically to attendances rendered by medical practitioners who are either: listed on the Vocational Register of General Practitioners maintained by the Health Insurance Commission; holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) and who participate in, and meet the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Programme; or undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or recognised by the RACGP as being at an equivalent standard. Only general practitioners are eligible to itemise these content-based items. (See paragraphs 3.1, 3.2 and 3.3 of the General Explanatory Notes for details of eligibility and registration).

A.4.2 Items 3 to 51 cover four categories of general practitioner attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

A.4.3 The attendances are divided into four categories relating to the level of complexity, namely:

(i) Level A - (10 relative value units)
(ii) Level B - (21 relative value units)
(iii) Level C - (38 relative value units)
(iv) Level D - (56 relative value units)

A.4.4 To assist medical practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes and examples in respect of the various levels are given. The fact that a particular case is used as an example does not mean that such cases would always be claimed at the level used in the example. Other modifying circumstances might prevail and each case must be treated on its merits.

LEVEL A

These items are for the obvious and straightforward cases and the practitioner's records would reflect this. In this context 'limited examination' means examination of the affected part if required, and 'management' the action taken.

Example: Triple Antigen or Tetanus Immunisation

LEVEL B
The descriptions of these items introduce the words 'selective history' and 'implementation of a management plan in relation to one or more problems'. In this context a 'selective history' means a history relating to a specific problem or condition; and 'implementation of a management plan' includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels A and B relate not to time but to complexity
Example: Otitis media presenting as earache

LEVEL C
Further levels of complexity are implied in these items by the introduction of 'taking a detailed history' and 'examination of multiple systems'. A physical attendance of at least 20 minutes is necessary to qualify for a Level C attendance. The words following 'OR' in the items for Levels B and C allow for the situation where an attendance involves some components of a more complex level but the time taken is less than specified in the higher level. Benefit is claimable at the appropriate lower level, e.g.; if an attendance involved a detailed history and examination of multiple systems, arranging investigations and implementing a management plan, but the time taken was less than 20 minutes, it would constitute a Level B attendance.
Example: Essential hypertension presenting as headache

LEVEL D
These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.
Examples: Migraine with peripheral neurological signs
Depression presenting as insomnia or headaches
Complex psychological or family relationship problems

Counselling or Advice to Patients or Relatives
A.4.5 For Items 23 to 51 'implementation of a management plan' includes counselling services.
A.4.6 Items 3 to 51 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes
A.4.7 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance
A.4.8 Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 13.3 of the General Explanatory Notes for further details).

After Hours Services
A.4.9 There are no differential Schedule fees for medical services rendered after hours, except in relation to the items for emergencies i.e. Items 97, 98. However, use of these emergency after hours items are restricted to situations as outlined in paragraph A.9 below.

Locum-Tenens
A.4.10 Where a general practitioner engages, either as an assistant or as a locum tenens, a medical practitioner who is not a general practitioner, Medicare benefits in respect of attendances rendered by the latter are attracted under items 52-96 and not under Items 3-51.

A.5 Professional Attendances at an Institution (Items 13,25, 38, 48, 81, 83, 84, 86)
A.5.1 For the purposes of these items an "institution" means a place (not being a hospital, nursing home, aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a nursing home complex) at which residential accommodation or day care or both such accommodation and such care is made available to:-
(a) disadvantaged children;
(b) juvenile offenders;
(c) aged persons;
(d) chronically ill psychiatric patients;
(e) homeless persons;
(f) unemployed persons;
(g) persons suffering from alcoholism;

(h) persons addicted to drugs; or
(i) physically or mentally handicapped persons.

Note: See also paragraph A.8

A.6 Attendances at a Hospital (Items 19, 33, 40, 50, 87, 89, 90, 91)

A.6.1 These items refer to attendances on patients admitted to a hospital or day hospital facility. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, surgery consultation items would apply.

Note: See also paragraph A.8

A.7 Nursing Home Attendances (Items 20, 35, 43, 51, 92, 93, 95, 96)

A.7.1 These items refer to attendances on patients in nursing homes but also include attendances on patients in aged persons' accommodation such as hostels attached to or in the grounds of a nursing home.

A.7.2 Where a medical practitioner attends a patient in a self-contained unit, within a nursing home complex, the attendance attracts benefits under the appropriate home visit item.

A.7.3 Where a patient living in a self-contained unit attends a medical practitioner at consulting rooms situated within the precincts of the nursing home or hostel, or at free standing consulting rooms within the nursing home complex, the appropriate surgery consultation item applies.

A.7.4 If a patient who is accommodated in the nursing home or hostel visits a medical practitioner at consulting rooms situated within the nursing home complex, whether free standing or situated within the nursing home or hostel precincts, benefits would be attracted under the appropriate nursing home attendance item.

Note: See also paragraph A.8

A.8 Attendances at Hospitals, Nursing Homes and Institutions

A.8.1 To facilitate assessment of the correct Medicare rebate in respect of a number of patients attended on the one occasion in the one hospital, nursing home or institution, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment form. For example, where ten patients were visited (for a brief consultation) in the one nursing home on the one occasion, each account, receipt or assignment form would show "Item 20 - 1 of 10 patients" for a General Practitioner.

A.9 Emergency After-Hours Attendances (Items 97, 98)

A.9.1 Items 97 and 98 should only be itemised in the following instances -

- the consultation is initiated by or on behalf of the patient in the same unbroken after-hours period (see para A.9.3);
- the patient's medical condition must require immediate treatment; and
- if more than one patient is seen on the one occasion, Items 97 and 98 can be used but only in respect of the first patient.

Where the patient is seen at a public hospital the following additional provisions would apply in relation to Item 97 -

- the first or only patient is a private in-patient; or
- the first or only patient is seen in the Out-patient or Casualty Department and the hospital does not provide at the time a medical Out-patient or Casualty service.

Where any of the above conditions do not apply the normal Schedule items should be itemised.

A.9.2 Item 98 is intended to allow benefit for returning to and specially opening up consulting rooms to attend a patient who needs immediate treatment after hours. As the extra benefit is for the inconvenience of actually returning to and opening the surgery it is payable only once on any one occasion - to the first patient seen after opening up. If other patients are seen on the same occasion they are itemised as ordinary surgery attendances. In this respect Item 98 is the same as Item 97.

Definition of After Hours

A.9.3 An after hours consultation or visit is a reference to an attendance on a public holiday, on a Sunday, before 8 a.m. or after 1 p.m. on a Saturday, or at any time other than between 8 a.m. and 8 p.m. on a week day not being a public holiday.

A.10 Minor Attendance by a Consultant Physician (Items 119, 131)

A.10.1 The Health Insurance Regulations provide that a minor consultation is regarded as being a consultation in which the assessment of the patient does not require the physical examination of the patient and does not involve a substantial alteration to the patient's treatment. Examples of consultations which could be regarded as being 'minor consultations' are listed below (this is by no means an exhaustive list) :-

- hospital visits where a physical examination does not result, or where only a limited examination is performed;
- hospital visits where a significant alteration to the therapy or overall management plan does not ensue;
- brief consultations or hospital visits not involving subsequent discussions regarding patient's progress with a specialist colleague or the referring practitioner.

A.11 Interview of Person other than a Patient by Consultant Psychiatrist (Items 157, 158 and 159)

A.11.1 Items 157 and 158 refer to investigative interviews of a patient's relatives or close associates to determine whether the particular problem with which the patient presented was focused in the patient or in the interaction between the patient and the person being interviewed. These items do not cover counselling of family or friends of the patient. The term "in the course of initial diagnostic evaluation of the patient" should normally be interpreted as extending for up to one month from the date of the initial consultation. There is no strict limit to the number of interviews or persons interviewed in that period. These items should not be used for interviews concerned with the continuing management of the patient. (see para A.11.2)

A.11.2 Item 159 refers to investigative interviews of a patient's relatives or close associates to focus on a particular clinically relevant problem arising in the continuing management of the patient. This item does not cover counselling of family or friends of the patient. The payment of Medicare benefits under this item is limited to two in any twelve month period.

A.11.3 Benefits are payable for Item 157, 158 or 159 and for a consultation with a patient (Items 134 - 152) on the same day provided that separate attendances are involved.

A.11.4 For Medicare benefit purposes, charges relating to services covered by Items 157, 158 and 159 should be raised against the patient rather than against the person interviewed.

A.12 Prolonged Attendance in Treatment of a Critical Condition (Items 160-164)

A.12.1 The conditions to be met before services covered by Items 160-164 attract benefits are -

(i) the patient must be in imminent danger of death;
(ii) the patient must be receiving continuous life-saving emergency treatment;
(iii) the constant presence of the medical practitioner must be necessary for the treatment to be maintained; and
(iv) the attention rendered in that period must be to the exclusion of all other patients.

A.13 Family Group Therapy (Items 170, 171, 172)

A.13.1 These items refer to family group therapy supervised by medical practitioners other than consultant psychiatrists. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

A.14 Acupuncture (Item 173)

A.14.1 The service of "acupuncture" must be performed by a medical practitioner and itemised under Item 173 to attract benefits. This item covers not only the performance of the acupuncture but includes any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given.

A.14.2 Other items in Category 1 of the Schedule should not be itemised for professional attendances when the service "acupuncture" is provided.

A.14.3 For the purpose of payment of Medicare benefits "acupuncture" is interpreted as including treatment by means other than the use of acupuncture needles where the same effect is achieved without puncture, e.g., by application of ultrasound, laser beams, pressure or moxibustion, etc.

A.15 Contact Lenses (Items 10801-10809)

A.15.1 Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie. patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in Items 10801 to 10809. Benefits are not payable for Item 10809 in circumstances where patients want contact lenses only for:

(a) reasons of appearance (because they do not want to wear spectacles);
(b) sporting purposes;
(c) work purposes; or
(d) psychological reasons (because they cannot cope with spectacles).

A.15.2 Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses.

A.15.3 Subsequent follow-up attendances attract benefits on a consultation basis.

A.16 Refitting of Contact Lenses (Item 10815)

A.16.1 This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit. A nominal fee only has been set for this item, the intention being that where the service becomes necessary an application will be made under the provisions of Section 11 of the Health Insurance Act and an appropriate fee will be determined by the Medicare Benefits Advisory Committee (see paragraph 9.2 of the General Explanatory Notes for details relating to the lodgement of such claims). Determinations by the Advisory Committee will be made on the basis of a list of conditions drawn up by the Department in consultation with the Royal Australian College of Ophthalmologists.

FEES AND BENEFITS FOR GP ATTENDANCES AT A NURSING HOME, HOSPITAL OR INSTITUTION

	LEVEL A			LEVEL B		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	28.55	24.30	21.45	41.25	35.10	30.95
TWO	20.00	17.00	15.00	32.70	27.80	24.55
THREE	17.15	14.60	12.90	29.85	25.40	22.40
FOUR	15.75	13.40	11.85	28.45	24.20	21.35
FIVE	14.90	12.70	11.20	27.60	23.50	20.70
SIX	14.30	12.20	10.75	27.00	22.95	20.25
SEVEN+	12.60	10.75	9.45	25.30	21.55	19.00

	LEVEL C			LEVEL D		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	60.65	51.60	45.50	81.30	69.15	61.00
TWO	52.10	44.30	39.10	72.75	61.85	54.60
THREE	49.25	41.90	36.95	69.90	59.45	52.45
FOUR	47.85	40.70	35.90	68.50	58.25	51.40
FIVE	47.00	40.00	35.25	67.65	57.55	50.75
SIX	46.40	39.45	34.80	67.05	57.00	50.30
SEVEN+	44.70	38.00	33.55	65.35	55.55	49.05

FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES AT A NURSING HOME, HOSPITAL OR INSTITUTION

	BRIEF			STANDARD		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	21.50	18.30	16.15	31.50	26.80	23.65
TWO	16.25	13.85	12.20	26.25	22.35	19.70
THREE	14.50	12.35	10.90	24.50	20.85	18.40
FOUR	13.65	11.65	10.25	23.65	20.15	17.75
FIVE	13.10	11.15	9.85	23.10	19.65	17.35
SIX	12.75	10.85	9.60	22.75	19.35	17.10
SEVEN+	11.70	9.95	8.80	21.70	18.45	16.30

	LONG			PROLONGED		
	FEE	BENEFITS		FEE	BENEFITS	
PATIENTS		85%	75%		85%	75%
ONE	48.50	41.25	36.40	71.50	60.80	53.65
TWO	43.25	36.80	32.45	66.25	56.35	49.70
THREE	41.50	35.30	31.15	64.50	54.85	48.40
FOUR	40.65	34.60	30.50	63.65	54.15	47.75
FIVE	40.10	34.10	30.10	63.10	53.65	47.35
SIX	39.75	33.80	29.85	62.75	53.35	47.10
SEVEN+	38.70	32.90	29.05	61.70	52.45	46.30

GROUP A1 - GENERAL PRACTITIONER ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

NOTE:
Professional attendances by general practitioners cover consultations during which the general practitioner evaluates the patient's problem (which may include certain health screening services - see paragraph 12.3 of the General Explanatory Notes) and formulates a management plan, in relation to one or more conditions present in the patient. The service also includes advice to the patient and/or relatives and the recording of appropriate detail of the particular services - (see paragraphs A.4.6 - A.4.7 of Explanatory Notes to this Category)

LEVEL 'A'

Professional attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.4 of explanatory notes to this Category)

3 **Fee:** $11.45 **Benefit:** 75% = $8.60 85% = $9.75

HOME VISIT
(Professional attendance at a place other than consulting rooms, hospital, nursing home or institution)
(See para A.4 of explanatory notes to this Category)

4 **Fee:** $28.65 **Benefit:** 75% = $21.50 85% = $24.40

CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient
(See para A.4 and A.5 of explanatory notes to this Category)

13 **Derived Fee:** The fee for Item 3, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 3 plus $1.15 per patient

CONSULTATION AT A HOSPITAL
(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient
(See para A.4 and A.6 of explanatory notes to this Category)

19 **Derived Fee:** The fee for Item 3, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 3 plus $1.15 per patient

CONSULTATION AT A NURSING HOME
(Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient
(See para A.4 and A.7 of explanatory notes to this Category)

20 **Derived Fee:** The fee for Item 3, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 3 plus $1.15 per patient

LEVEL 'B'

Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.4 of explanatory notes to this Category)

23 **Fee:** $24.15 **Benefit:** 75% = $18.15 85% = $20.55

HOME VISIT
(Professional attendance at a place other than consulting rooms, hospital, nursing home or institution)
(See para A.4 of explanatory notes to this Category)

24 **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10

25	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.4 and A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 23, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 23 plus $1.15 per patient
33	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.4 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 23, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 23 plus $1.15 per patient
35	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.4 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 23, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 23 plus $1.15 per patient
36	**LEVEL 'C'** Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies **SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.4 of explanatory notes to this Category)* **Fee:** $43.55 **Benefit:** 75% = $32.70 85% = $37.05
37	**HOME VISIT** (Professional attendance at a place other than consulting rooms, hospital, nursing home, or institution) *(See para A.4 of explanatory notes to this Category)* **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
38	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.4 and A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 36, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 36 plus $1.15 per patient
40	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.4 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 36, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients-the fee for Item 36 plus $1.15 per patient
43	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.4 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 36, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 36 plus $1.15 per patient

	LEVEL 'D' Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan
44	**SURGERY CONSULTATION** (Professional attendance at consulting rooms) *(See para A.4 of explanatory notes to this Category)* **Fee:** $64.20 **Benefit:** 75% = $48.15 85% = $54.60
47	**HOME VISIT** (Professional attendance at a place other than consulting rooms, hospital, nursing home or institution) *(See para A.4 of explanatory notes to this Category)* **Fee:** $81.40 **Benefit:** 75% = $61.05 85% = $69.20
48	**CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME** (Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient *(See para A.4 and A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 44, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient
50	**CONSULTATION AT A HOSPITAL** (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient *(See para A.4 and A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 44, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient
51	**CONSULTATION AT A NURSING HOME** (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient *(See para A.4 and A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 44, plus $17.10 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 44 plus $1.15 per patient

GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SURGERY CONSULTATIONS

(Professional attendance at consulting rooms)

52	**BRIEF CONSULTATION** of not more than 5 minutes duration **Fee:** $11.00 **Benefit:** 75% = $8.25 85% = $9.35
53	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration **Fee:** $21.00 **Benefit:** 75% = $15.75 85% = $17.85
54	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration **Fee:** $38.00 **Benefit:** 75% = $28.50 85% = $32.30
57	**PROLONGED CONSULTATION** of more than 45 minutes duration **Fee:** $61.00 **Benefit:** 75% = $45.75 85% = $51.85

HOME VISITS

(Professional attendance at a place other than consulting rooms, hospital, nursing home or institution)

58	**BRIEF HOME VISIT** of not more than 5 minutes duration **Fee:** $24.00 **Benefit:** 75% = $18.00 85% = $20.40
59	**STANDARD HOME VISIT** of more than 5 minutes duration but not more than 25 minutes duration **Fee:** $31.50 **Benefit:** 75% = $23.65 85% = $26.80
60	**LONG HOME VISIT** of more than 25 minutes duration but not more than 45 minutes duration **Fee:** $51.00 **Benefit:** 75% = $38.25 85% = $43.35
65	**PROLONGED HOME VISIT** of more than 45 minutes duration **Fee:** $73.00 **Benefit:** 75% = $54.75 85% = $62.05

CONSULTATION AT AN INSTITUTION - OTHER THAN A HOSPITAL OR NURSING HOME

(Professional attendance on 1 or more patients in 1 institution on 1 occasion) - each patient

81	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 52, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 52 plus $0.70 per patient
83	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 53, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 53 plus $0.70 per patient
84	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 54, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 54 plus $0.70 per patient
86	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.5 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 57, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 57 plus $0.70 per patient

	CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) - each patient
87	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 52, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 52 plus $0.70 per patient
89	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 53, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 53 plus $0.70 per patient
90	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 54, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 54 plus $0.70 per patient
91	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.6 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 57, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 57 plus $0.70 per patient
	CONSULTATION AT A NURSING HOME (Professional attendance on 1 or more patients in 1 nursing home including aged persons' accommodation attached to a nursing home or aged persons' accommodation situated within a complex that includes a nursing home (but excluding a professional attendance at a self contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the nursing home or aged persons' accommodation (excluding accommodation in a self-contained unit) on 1 occasion) - each patient
92	**BRIEF CONSULTATION** of not more than 5 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 52, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 52 plus $0.70 per patient
93	**STANDARD CONSULTATION** of more than 5 minutes duration but not more than 25 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 53, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 53 plus $0.70 per patient
95	**LONG CONSULTATION** of more than 25 minutes duration but not more than 45 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 54, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 54 plus $0.70 per patient
96	**PROLONGED CONSULTATION** of more than 45 minutes duration *(See para A.7 of explanatory notes to this Category)* **Derived Fee:** The fee for Item 57, plus $10.50 divided by the number of patients seen, up to a maximum of 6 patients. For 7 or more patients - the fee for Item 57 plus $0.70 per patient

GROUP A3 - EMERGENCY AFTER HOURS ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

EMERGENCY ATTENDANCE - AFTER HOURS
(on not more than 1 patient on 1 occasion)

97 Professional attendance after hours AT A PLACE OTHER THAN CONSULTING ROOMS on not more than 1 patient on 1 occasion where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance
(See para A.9 of explanatory notes to this Category)
Fee: $45.50 **Benefit:** 75% = $34.15 85% = $38.70

98 Professional attendance after hours AT CONSULTING ROOMS on not more than 1 patient on 1 occasion where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period, where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance
(See para A.9 of explanatory notes to this Category)
Fee: $45.50 **Benefit:** 75% = $34.15 85% = $38.70

GROUP A4 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

SPECIALIST, REFERRED CONSULTATION - SURGERY, HOSPITAL OR NURSING HOME
(Professional attendance at consulting rooms, hospital or nursing home by a specialist in the practice of his or her specialty where the patient is referred to him or her)

104 - **INITIAL** attendance in a single course of treatment, not being a service to which item 106 applies
Fee: $61.00 **Benefit:** 75% = $45.75 85% = $51.85

105 - Each attendance **SUBSEQUENT** to the first in a single course of treatment
Fee: $30.50 **Benefit:** 75% = $22.90 85% = $25.95

106 - **INITIAL ATTENDANCE** in a single course of treatment, being an attendance at which refraction is performed by a specialist ophthalmologist, and the attendance results in the issuing of a prescription for spectacles or contact lenses, including any consultation on the same occasion and any other attendance on the same day (other than a service to which items 10801 to 10815 apply)
Fee: $50.15 **Benefit:** 75% = $37.65 85% = $42.65

SPECIALIST, REFERRED CONSULTATION - HOME VISITS
(Professional attendance at a place other than consulting rooms, hospital or nursing home by a specialist in the practice of his or her specialty where the patient is referred to him or her)

107 - **INITIAL** attendance in a single course of treatment
Fee: $89.30 **Benefit:** 75% = $67.00 85% = $75.95

108 - Each attendance **SUBSEQUENT** to the first in a single course of treatment
Fee: $56.50 **Benefit:** 75% = $42.40 85% = $48.05

GROUP A5 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - SURGERY, HOSPITAL OR NURSING HOME

(Professional attendance at consulting rooms, hospital or nursing home by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)

110	- **INITIAL** attendance in a single course of treatment **Fee:** $107.45 **Benefit:** 75% = $80.60 85% = $91.35
116	- Each attendance (other than a service to which item 119 applies) **SUBSEQUENT** to the first in a single course of treatment **Fee:** $53.75 **Benefit:** 75% = $40.35 85% = $45.70
119	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.10 of explanatory notes to this Category)* **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95

CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - HOME VISITS

(Professional attendance at a place other than consulting rooms, hospital or nursing home by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)

122	- **INITIAL** attendance in a single course of treatment **Fee:** $130.40 **Benefit:** 75% = $97.80 85% = $110.85
128	- Each attendance (other than a service to which item 131 applies) **SUBSEQUENT** to the first in a single course of treatment **Fee:** $78.80 **Benefit:** 75% = $59.10 85% = $67.00
131	- Each **MINOR** attendance **SUBSEQUENT** to the first in a single course of treatment *(See para A.10 of explanatory notes to this Category)* **Fee:** $56.75 **Benefit:** 75% = $42.60 85% = $48.25

GROUP A6 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION SURGERY, HOSPITAL OR NURSING HOME

(Professional attendance at consulting rooms, hospital or nursing home by a consultant physician in the practice of his or her specialty of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)

134	- An attendance of not more than 15 minutes duration **Fee:** $30.80	**Benefit:**	75% = $23.10	85% = $26.20	
136	- An attendance of more than 15 minutes duration but not more than 30 minutes duration **Fee:** $61.60	**Benefit:**	75% = $46.20	85% = $52.40	
138	- An attendance of more than 30 minutes duration but not more than 45 minutes duration **Fee:** $90.30	**Benefit:**	75% = $67.75	85% = $76.80	
140	- An attendance of more than 45 minutes duration but not more than 75 minutes duration **Fee:** $124.65	**Benefit:**	75% = $93.50	85% = $106.00	
142	- An attendance of more than 75 minutes duration **Fee:** $151.90	**Benefit:**	75% = $113.95	85% = $129.15	

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION - HOME VISITS

(Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY where the patient is referred to him or her by a medical practitioner - where that attendance is at a place other than consulting rooms, hospital or nursing home)

144	- An attendance of not more than 15 minutes duration **Fee:** $56.60	**Benefit:**	75% = $42.45	85% = $48.15	
146	- An attendance of more than 15 minutes duration but not more than 30 minutes duration **Fee:** $88.85	**Benefit:**	75% = $66.65	85% = $75.55	
148	- An attendance of more than 30 minutes duration but not more than 45 minutes duration **Fee:** $123.25	**Benefit:**	75% = $92.45	85% = $104.80	
150	- An attendance of more than 45 minutes duration but not more than 75 minutes duration **Fee:** $149.05	**Benefit:**	75% = $111.80	85% = $126.70	
152	- An attendance of more than 75 minutes duration **Fee:** $177.70	**Benefit:**	75% = $133.30	85% = $151.05	
153	**ATTENDANCE FOR ELECTROCONVULSIVE THERAPY**, including associated consultation (AU 3 - 17903) **Fee:** $40.55	**Benefit:**	75% = $30.45	85% = $34.50	

CONSULTANT PSYCHIATRIST - GROUP PSYCHOTHERAPY

Group psychotherapy (including any associated consultation with a patient taking place on the same occasion and relating to the condition for which group therapy is conducted) of not less than 1 hours duration given under the continuous direct supervision of a consultant physician in the practice of his or her specialty of psychiatry where the patients are referred to him or her by a medical practitioner.

154	- GROUP PSYCHOTHERAPY on a group of 2-9 unrelated patients OR FAMILY GROUP psychotherapy on a group of more than 3 patients, EACH PATIENT **Fee:** $35.15	**Benefit:**	75% = $26.40	85% = $29.90	
155	- FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT **Fee:** $46.65	**Benefit:**	75% = $35.00	85% = $39.70	
156	- FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT **Fee:** $68.95	**Benefit:**	75% = $51.75	85% = $58.65	

CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF INITIAL DIAGNOSTIC EVALUATION OF A PATIENT

Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient in the course of initial diagnostic evaluation of a patient

- An attendance of not less than 20 minutes duration but less than 45 minutes duration

(See para A.11 of explanatory notes to this Category)

157 **Fee:** $37.20 **Benefit:** 75% = $27.90 85% = $31.65

- An attendance of not less than 45 minutes duration

(See para A.11 of explanatory notes to this Category)

158 **Fee:** $83.80 **Benefit:** 75% = $62.85 85% = $71.25

CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF CONTINUING MANAGEMENT OF A PATIENT

Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient in the course of continuing management of a patient - **payable not more than twice in any 12 month period**

- An attendance of not less than 20 minutes duration

(See para A.11 of explanatory notes to this Category)

159 **Fee:** $37.25 **Benefit:** 75% = $27.95 85% = $31.70

GROUP A7 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PROLONGED PROFESSIONAL ATTENDANCES

(Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death requiring continuous life saving emergency treatment (not being treatment of a counselling nature) to the exclusion of all other patients)

160	- For a period of not less than 1 hour but less than 2 hours *(See para A.12 of explanatory notes to this Category)*	**Fee:** $87.55	**Benefit:**	75% = $65.70	85% = $74.45
161	- For a period of not less than 2 hours but less than 3 hours *(See para A.12 of explanatory notes to this Category)*	**Fee:** $143.00	**Benefit:**	75% = $107.25	85% = $121.55
162	- For a period of not less than 3 hours but less than 4 hours *(See para A.12 of explanatory notes to this Category)*	**Fee:** $198.45	**Benefit:**	75% = $148.85	85% = $170.75
163	- For a period of not less than 4 hours but less than 5 hours *(See para A.12 of explanatory notes to this Category)*	**Fee:** $253.85	**Benefit:**	75% = $190.40	85% = $226.15
164	- For a period of 5 hours or more *(See para A.12 of explanatory notes to this Category)*	**Fee:** $306.40	**Benefit:**	75% = $229.80	85% = $278.70

GROUP A8 - GROUP THERAPY

FAMILY GROUP THERAPY

(Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family)

170	- each group of 2 patients *(See para A.13 of explanatory notes to this Category)* **Fee:** $92.00 **Benefit:** 75% = $69.00 85% = $78.20
171	- each group of 3 patients *(See para A.13 of explanatory notes to this Category)* **Fee:** $97.00 **Benefit:** 75% = $72.75 85% = $82.45
172	- each group of 4 or more patients *(See para A.13 of explanatory notes to this Category)* **Fee:** $118.00 **Benefit:** 75% = $88.50 85% = $100.30

GROUP A9 - ACUPUNCTURE

173	ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed *(See para A.14 of explanatory notes to this Category)* **Fee:** $21.50 **Benefit:** 75% = $16.15 85% = $18.30

GROUP A10 - CONTACT LENSES

CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS

Note: Benefits may not be claimed under Item 10809 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons

ATTENDANCE FOR THE INVESTIGATION and EVALUATION of a patient for the fitting of CONTACT LENSES, with keratometry and testing with trial lenses and the issue of a prescription - 1 SERVICE IN ANY PERIOD OF 36 CONSECUTIVE MONTHS

10801	- patients with myopia of 4.0 dioptres or greater (spherical equivalent) in 1 eye *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10802	- patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10803	- patients with astigmatism of 3.0 dioptres or greater in 1 eye *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10804	- patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is less than 6/12 and if that corrected acuity would be improved by an additional 1 line on the Snellen chart by the use of a contact lens *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10805	- patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10806	- patients with subnormal corrected visual acuity of not greater than 6/30 in either eye, being patients for whom a contact lens is prescribed as part of a telescopic system *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10807	- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: (i) pathological mydriasis; or (ii) aniridia; or (iii) coloboma of the iris; or (iv) pupillary malformation or distortion; or (v) significant ocular deformity or corneal opacity whether congenital, traumatic or surgical in origin *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10808	- patients who, by reason of physical deformity, are unable to wear spectacles *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10809	- patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806, 10807 or 10808 applies) requiring the use of a contact lens for correction and which condition must be specified on the patient's account *(See para A.15 of explanatory notes to this Category)* **Fee:** $86.75 **Benefit:** 75% = $65.10 85% = $73.75
10815	ATTENDANCE FOR REFITTING of CONTACT LENSES with keratometry and testing with trial lenses and the issue of a prescription being a subsequent fitting of contact lenses within a period of 36 months of the initial fitting to which items 10801 to 10809 apply *(See para A.16 of explanatory notes to this Category)* **Fee:** $6.20 **Benefit:** 75% = $4.65 85% = $5.30

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

CATEGORY 2

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

D1.1 Investigation of Central Nervous System Evoked Responses (Items 11024 and 11027)

D1.1.1 In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

D1.1.2 Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

D1.1.3 Items 11024 and 11027 are not intended to cover bio-feedback techniques.

D1.2 Computerised Perimetry (Item 11227)

D1.2.1 This item relates to computerised perimetry where a third or subsequent examination becomes necessary in a twelve month period. A nominal fee only has been set for the item, the intention being that where additional investigations become necessary an application will be made under the provisions of Section 11 of the Health Insurance Act and an appropriate fee will be determined by the Medicare Benefits Advisory Committee (see paragraph 9.2 of the General Explanatory Notes for details relating to the lodgement of such claims).

D1.3 Electrocochleography (Item 11303)

D1.3.1 This item refers to electrocochleography including the insertion of electrodes in one or both ears.

D1.4 Non-determinate Audiometry (Item 11306)

D1.4.1 This refers to screening audiometry covering those services, one or more, referred to in Items 11309-11321 when not performed under the conditions set out in paragraph D1.5.1.

D1.5 Audiology Services (Items 11309 - 11321)

D1.5.1 A medical service specified in Items 11309 to 11321 shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

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

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

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

D1.6 Respiratory Function Tests (Item 11503)

D1.6.1 The investigations listed hereunder would attract benefits under Item 11503. This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

(a) Carbon monoxide diffusing capacity by any method
(b) Absolute lung volumes by any method
(c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method
(d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure
(e) Measurement of airway or pulmonary resistance by any method
(f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures
(g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm
(h) Measurement of the resistance of the anterior nares or pharynx
(i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents or non-istonic fluids and post-bronchodilator spirometry
(j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator
(k) Tests of distribution of ventilation involving inhalation of inert gases
(l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood
(m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung
(n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation; of at least 6 hours duration
(o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia
(p) Monitoring pulmonary arterial pressure at rest or during exercise
(q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes

(r) Measurement of the respiratory muscle endurance/fatigability by any technique
(s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs.
(t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
(u) Inhalation provocation testing to specific sensitising agents
(v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator.

D1.7 Investigations of Vascular Disease (Items 11603-11624)
D1.7.1 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.

D1.8 Twelve-lead Electrocardiography (Item 11700)
D1.8.1 Benefits are precluded under this item unless a full 12-lead ECG is performed. Examinations involving less than twelve leads are regarded as part of the accompanying consultation. A 12-lead ECG refers to the recordings produced of 12 views of the heart by various combinations of placement of electrodes.

D1.9 Twelve-lead Electrocardiography, Report Only (Item 11701)
D1.9.1 This item provides a benefit where tracings are referred to a medical practitioner for a report without an attendance on the patient by that practitioner. Where a patient is referred to a consultant for a consultation and takes ECG tracings with him/her, benefits are not attracted for the consultant's interpretation of the tracings.

D1.10 Electrocardiographic Recording of Ambulatory Patient (Item 11709)
D1.10.1 This item requires the continuous recording of an ambulatory patient for twelve hours or more and the analysis of the recording on a Holter scan system.
D1.10.2 This item covers the investigation regardless of the actual time involved in the monitoring. The changing of a tape or batteries is regarded as a continuation of the service and does not constitute a separate service for benefit purposes. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode would be regarded as a separate service. D1.10.3 The electrocardiographic monitoring of ambulatory patients in other circumstances does not attract a benefit under this item.

D1.11 Electrocardiographic Monitoring During Exercise (Item 11712)
D1.11.1 The requirements for the payment of benefits under this item is the presence of the medical practitioner with the patient for not less than twenty minutes and the premises to be equipped with mechanical ventilator and defibrillator.
Note - Items 11709 and 11712 also include resting ECG and the recording of other parameters.

D1.12 Investigations for Sleep Apnoea (Item 12206)
D1.12.1 This item relates to overnight sleep apnoea investigations where it becomes necessary to conduct in excess of three such investigations in a twelve month period. A nominal fee only has been set for the item, the intention being that where additional investigations become necessary an application will be made under the provisions of Section 11 of the Health Insurance Act and an appropriate fee will be determined by the Medicare Benefits Advisory Committee (see paragraph 9.2 of the General explanatory Notes for details relating to the lodgement of such claims).

	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 1 - NEUROLOGY
11000	ELECTROENCEPHALOGRAPHY, not being a service associated with a service to which item 11003, 11006 or 11009 applies (AU 6 - 17906) **Fee:** $87.60 **Benefit:** 75% = $65.70 85% = $74.50
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service associated with a service to which item 11000, 11006 or 11009 applies **Fee:** $232.00 **Benefit:** 75% = $174.00 85% = $204.30
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal **Fee:** $118.95 **Benefit:** 75% = $89.25 85% = $101.15
11009	ELECTROCORTICOGRAPHY **Fee:** $162.20 **Benefit:** 75% = $121.65 85% = $137.90
11012	NEUROMUSCULAR ELECTRODIAGNOSIS - conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) **Fee:** $79.75 **Benefit:** 75% = $59.85 85% = $67.80
11015	NEUROMUSCULAR ELECTRODIAGNOSIS - conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) **Fee:** $106.80 **Benefit:** 75% = $80.10 85% = $90.80
11018	NEUROMUSCULAR ELECTRODIAGNOSIS - conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) **Fee:** $159.50 **Benefit:** 75% = $119.65 85% = $135.60
11021	NEUROMUSCULAR ELECTRODIAGNOSIS - repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations **Fee:** $106.80 **Benefit:** 75% = $80.10 85% = $90.80
11024	INVESTIGATION OF CENTRAL NERVOUS SYSTEM EVOKED RESPONSES by computerised averaging techniques - 1 or 2 studies *(See para D1.1 of explanatory notes to this Category)* **Fee:** $81.10 **Benefit:** 75% = $60.85 85% = $68.95
11027	INVESTIGATION OF CENTRAL NERVOUS SYSTEM EVOKED RESPONSES by computerised averaging techniques - 3 or more studies *(See para D1.1 of explanatory notes to this Category)* **Fee:** $120.30 **Benefit:** 75% = $90.25 85% = $102.30
	SUBGROUP 2 - OPHTHALMOLOGY
11200	PROVOCATIVE TEST OR TESTS FOR GLAUCOMA, including water drinking **Fee:** $29.05 **Benefit:** 75% = $21.80 85% = $24.70
11203	TONOGRAPHY - in the investigation or management of glaucoma, 1 or both eyes - using an electrical tonography machine producing a directly recorded tracing **Fee:** $49.15 **Benefit:** 75% = $36.90 85% = $41.80
11206	ELECTRORETINOGRAPHY of 1 or both eyes OR ELECTRO-OCULOGRAPHY of 1 or both eyes **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60

11209	ELECTRORETINOGRAPHY of 1 or both eyes AND ELECTRO-OCULOGRAPHY of 1 or both eyes **Fee:** $116.10 **Benefit:** 75% = $87.10 85% = $98.70
11212	OPTIC FUNDI, examination of, following intravenous dye injection **Fee:** $49.95 **Benefit:** 75% = $37.50 85% = $42.50
11215	RETINAL PHOTOGRAPHY, multiple exposures of 1 eye with intravenous dye injection **Fee:** $97.20 **Benefit:** 75% = $72.90 85% = $82.65
11218	RETINAL PHOTOGRAPHY, multiple exposures of both eyes with intravenous dye injection **Fee:** $120.15 **Benefit:** 75% = $90.15 85% = $102.15
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:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
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:** $32.35 **Benefit:** 75% = $24.30 85% = $27.50
11227	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, an examination to which item 11221 or 11224 applies, being the third or subsequent examination in a 12 month period *(See para D1.2 of explanatory notes to this Category)* **Fee:** $5.65 **Benefit:** 75% = $4.25 85% = $4.85
	SUBGROUP 3 - OTOLARYNGOLOGY
11300	BRAIN stem evoked response audiometry (AU 6 - 17906) **Fee:** $137.05 **Benefit:** 75% = $102.80 85% = $116.50
‡ 11303	ELECTROCOCHLEOGRAPHY including the insertion of electrodes *(See para D1.3 of explanatory notes to this Category)* **Fee:** $135.75 **Benefit:** 75% = $101.85 85% = $115.40
11306	Non-determinate AUDIOMETRY *(See para D1.4 of explanatory notes to this Category)* **Fee:** $15.65 **Benefit:** 75% = $11.75 85% = $13.35
11309	AUDIOGRAM, air conduction *(See para D1.5 of explanatory notes to this Category)* **Fee:** $18.65 **Benefit:** 75% = $14.00 85% = $15.90
11312	AUDIOGRAM, air and bone conduction or air conduction and speech discrimination *(See para D1.5 of explanatory notes to this Category)* **Fee:** $26.45 **Benefit:** 75% = $19.85 85% = $22.50
11315	AUDIOGRAM, air and bone conduction and speech *(See para D1.5 of explanatory notes to this Category)* **Fee:** $35.10 **Benefit:** 75% = $26.35 85% = $29.85
11318	AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests *(See para D1.5 of explanatory notes to this Category)* **Fee:** $43.20 **Benefit:** 75% = $32.40 85% = $36.75

11321	GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests) *(See para D1.5 of explanatory notes to this Category)* **Fee:** $82.15 **Benefit:** 75% = $61.65 85% = $69.85
11324	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $23.45 **Benefit:** 75% = $17.60 85% = $19.95
11327	IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies **Fee:** $14.05 **Benefit:** 75% = $10.55 85% = $11.95
11330	IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period **Fee:** $5.65 **Benefit:** 75% = $4.25 85% = $4.85
11333	CALORIC TEST OF LABYRINTH OR LABYRINTHS **Fee:** $31.75 **Benefit:** 75% = $23.85 85% = $27.00
11336	SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS **Fee:** $31.95 **Benefit:** 75% = $24.00 85% = $27.20
11339	ELECTRONYSTAGMOGRAPHY **Fee:** $31.75 **Benefit:** 75% = $23.85 85% = $27.00
	SUBGROUP 4 - RESPIRATORY
11500	BRONCHOSPIROMETRY, including gas analysis **Fee:** $118.95 **Benefit:** 75% = $89.25 85% = $101.15
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:** $98.70 **Benefit:** 75% = $74.05 85% = $83.90
11506	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed **Fee:** $14.60 **Benefit:** 75% = $10.95 85% = $12.45
11509	MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (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 **Fee:** $25.45 **Benefit:** 75% = $19.10 85% = $21.65
11512	CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (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 **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45

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:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
11603	EXAMINATION OF PERIPHERAL VESSELS AT REST (unilateral or bilateral) with hard copy recordings of wave forms, involving 1 of the following techniques - Doppler recordings (pulsed, continuous wave, or both) of blood flow velocity with or without pulse volume recordings; Doppler recordings involving real time fast fourier transform analysis; venous occlusion plethysmography; air plethysmography; strain-gauge plethysmography; impedance plethysmography; or photo plethysmography; (not being a service associated with a service to which item 11612 or 11615 applies) - 1 examination and report *(See para D1.7 of explanatory notes to this Category)* **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30
11606	- 2 examinations of the kind referred to in item 11603 and report (not being a service associated with a service to which item 11612 or 11615 applies) *(See para D1.7 of explanatory notes to this Category)* **Fee:** $52.20 **Benefit:** 75% = $39.15 85% = $44.40
11609	- 3 or more examinations of the kind referred to in item 11603 and report (not being a service associated with a service to which item 11612 or 11615 applies) *(See para D1.7 of explanatory notes to this Category)* **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55
11612	EXAMINATION OF PERIPHERAL VESSELS and report, involving any of the techniques referred to in item 11603, with hard copy recording of wave forms before measured exercise using a treadmill or bicycle ergometer, and measurement of pressure after exercise for 10 minutes or until pressure is normal (unilateral or bilateral) *(See para D1.7 of explanatory notes to this Category)* **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55
11615	MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing *(See para D1.7 of explanatory notes to this Category)* **Fee:** $54.00 **Benefit:** 75% = $40.50 85% = $45.90
11618	EXAMINATION OF CAROTID VESSELS (unilateral or bilateral) with hard copy recordings of wave forms, involving 1 of the following techniques - Doppler real time fast fourier transform analysis; oculoplethysmography, phonoangiography or both; or periorbital Doppler examination (not being a service associated with a service to which item 55201, 55204, 55225 or 55231 applies) - 1 examination and report *(See para D1.7 of explanatory notes to this Category)* **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85
11621	- 2 examinations of the kind referred to in item 11618 and report (not being a service associated with a service to which item 55201, 55204, 55225 or 55231 applies) *(See para D1.7 of explanatory notes to this Category)* **Fee:** $72.40 **Benefit:** 75% = $54.30 85% = $61.55
11624	- 3 or more examinations of the kind referred to in item 11618 and report (not being a service associated with a service to which item 55201, 55204, 55225 or 55231 applies) *(See para D1.7 of explanatory notes to this Category)* **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70
11627	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age **Fee:** $162.90 **Benefit:** 75% = $122.20 85% = $138.50
11630	PULMONARY ARTERY pressure monitoring during open heart surgery, in a person over 12 years of age **Fee:** $60.45 **Benefit:** 75% = $45.35 85% = $51.40

SUBGROUP 6 - CARDIOVASCULAR

11700	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report *(See para D1.8 of explanatory notes to this Category)* **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
11701	TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, including any consultation on the same day *(See para D1.9 of explanatory notes to this Category)* **Fee:** $12.35 **Benefit:** 75% = $9.30 85% = $10.50
11702	TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only **Fee:** $12.35 **Benefit:** 75% = $9.30 85% = $10.50
11706	PHONOCARDIOGRAPHY with electrocardiograph lead with indirect arterial or venous pulse tracing, with or without apex cardiogram - interpretation and report **Fee:** $51.35 **Benefit:** 75% = $38.55 85% = $43.65
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 to which item 11709 applies **Fee:** $101.10 **Benefit:** 75% = $75.85 85% = $85.95
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:** $132.50 **Benefit:** 75% = $99.40 85% = $112.65
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:** $36.90 **Benefit:** 75% = $27.70 85% = $31.40
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:** $20.20 **Benefit:** 75% = $15.15 85% = $17.20
11712	ELECTROCARDIOGRAPHIC MONITORING during exercise (bicycle ergometer or treadmill) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG and with or without recording of other parameters, on premises equipped with mechanical respirator and defibrillator *(See para D1.11 of explanatory notes to this Category)* **Fee:** $120.30 **Benefit:** 75% = $90.25 85% = $102.30
11713	SIGNAL AVERAGED ELECTROCARDIOGRAPHIC RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording **Fee:** $49.65 **Benefit:** 75% = $37.25 85% = $42.25
11715	BLOOD DYE - DILUTION INDICATOR TEST **Fee:** $86.10 **Benefit:** 75% = $64.60 85% = $73.20
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700 or 11721 applies **Fee:** $24.80 **Benefit:** 75% = $18.60 85% = $21.10
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700 or 11718 applies **Fee:** $49.65 **Benefit:** 75% = $37.25 85% = $42.25

	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
11800	OESOPHAGEAL MOTILITY TEST, manometric **Fee:** $124.30 **Benefit:** 75% = $93.25 85% = $105.70
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation **Fee:** $122.05 **Benefit:** 75% = $91.55 85% = $103.75
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex **Fee:** $93.10 **Benefit:** 75% = $69.85 85% = $79.15
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency **Fee:** $177.90 **Benefit:** 75% = $133.45 85% = $151.25
	SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11918 applies **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which item 11912, 11915, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies **Fee:** $79.10 **Benefit:** 75% = $59.35 85% = $67.25
11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which item 11909, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies **Fee:** $79.10 **Benefit:** 75% = $59.35 85% = $67.25
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906, 11915, 11918, 36800 or any item in Group I3 applies **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which item 11903, 11915, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies (AU 6 - 17906) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11903, 11909, 11912, 11918, 11012-11027, 11921, 36800 or any item in Group I3 applies (AU 6 - 17906) **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
11918	CYSTOMETROGRAPHY with simultaneous measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; and all associated fluoroscopic imaging, not being a service associated with a service to which items 11900-11915, 11012-11027, 11921 and 36800 apply (AU 6 - 17906) **Fee:** $305.10 **Benefit:** 75% = $228.85 85% = $277.40
11921	BLADDER WASHOUT TEST for localisation of urinary infection - not including bacterial counts for organisms in specimens **Fee:** $53.40 **Benefit:** 75% = $40.05 85% = $45.40
	SUBGROUP 9 - ALLERGY TESTING
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:** $27.70 **Benefit:** 75% = $20.80 85% = $23.55

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:** $41.90 **Benefit:** 75% = $31.45 85% = $35.65
12006	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis, using 1 to 20 ALLERGENS **Fee:** $27.85 **Benefit:** 75% = $20.90 85% = $23.70
12009	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis, using more than 20 ALLERGENS **Fee:** $41.80 **Benefit:** 75% = $31.35 85% = $35.55
	SUBGROUP 10 - INTENSIVE CARE MANAGEMENT AND PROCEDURES
12100	ARTERIAL PUNCTURE and collection of blood for diagnostic purposes **Fee:** $16.40 **Benefit:** 75% = $12.30 85% = $13.95
12103	INTRA-ARTERIAL CANNULISATION for the purpose of taking multiple arterial blood samples for blood gas analysis **Fee:** $49.30 **Benefit:** 75% = $37.00 85% = $41.95
12106	COUNTERPULSATION BY INTRA-AORTIC BALLOON - management on the first day, including percutaneous insertion, initial and subsequent consultations and monitoring of parameters **Fee:** $385.30 **Benefit:** 75% = $289.00 85% = $357.60
12109	COUNTERPULSATION BY INTRA-AORTIC BALLOON - management on each day subsequent to the first, including associated consultations and monitoring of parameters **Fee:** $93.30 **Benefit:** 75% = $70.00 85% = $79.35
12112	CIRCULATORY SUPPORT DEVICE, management of, on first day **Fee:** $351.65 **Benefit:** 75% = $263.75 85% = $323.95
12115	CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first **Fee:** $81.70 **Benefit:** 75% = $61.30 85% = $69.45
	SUBGROUP 11 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis **Fee:** $26.50 **Benefit:** 75% = $19.90 85% = $22.55
12203	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, involving continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG, with continuous technician attendance, under the supervision of a consultant physician in the practice of his or her specialty of thoracic medicine or under the supervision of a specialist in a sleep laboratory of a recognised hospital, where the patient is referred to him or her by a medical practitioner, including interpretation by physician of recordings; payable no more than 3 times in any 12 month period (Ministerial Determination) **Fee:** $469.00 **Benefit:** 75% = $351.75 85% = $441.30
12206	OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, involving continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG, with continuous technician attendance, under the supervision of a consultant physician in the practice of his or her specialty of thoracic medicine or under the supervision of a specialist in a sleep laboratory of a recognised hospital, where the patient is referred to him or her by a medical practitioner, including interpretation by physician of recordings; being the fourth or subsequent investigation in a 12 month period (Ministerial Determination) *(See para D1.12 of explanatory notes to this Category)* **Fee:** $5.15 **Benefit:** 75% = $3.90 85% = $4.40

GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)

12500	BLOOD VOLUME ESTIMATION **Fee:** $154.25 **Benefit:** 75% = $115.70 85% = $131.15
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST **Fee:** $302.60 **Benefit:** 75% = $226.95 85% = $274.90
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens **Fee:** $215.95 **Benefit:** 75% = $162.00 85% = $188.25
12509	GASTROINTESTINAL PROTEIN LOSS **Fee:** $154.25 **Benefit:** 75% = $115.70 85% = $131.15
12512	RADIOACTIVE B12 ABSORPTION TEST - 1 isotope **Fee:** $74.75 **Benefit:** 75% = $56.10 85% = $63.55
12515	RADIOACTIVE B12 ABSORPTION TEST - 2 isotopes **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
12518	THYROID UPTAKE (using probe) **Fee:** $74.75 **Benefit:** 75% = $56.10 85% = $63.55
12521	PERCHLORATE DISCHARGE STUDY **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
12524	RENAL FUNCTION TEST (without imaging procedure) **Fee:** $112.75 **Benefit:** 75% = $84.60 85% = $95.85
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) **Fee:** $60.50 **Benefit:** 75% = $45.40 85% = $51.45
12530	WHOLE BODY COUNT - not being a service associated with a service to which another item applies **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70

THERAPEUTIC PROCEDURES

CATEGORY 3

CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

MISCELLANEOUS THERAPEUTIC PROCEDURES (Group T1)

T1.1 Hyperbaric Oxygen Therapy (Items 13000, 13003)

T1.1.1 These items relate to treatment for periods up to and including two hours. For periods in excess of two hours Item 13012 should be itemised.

T1.2 Haemodialysis (Items 13100, 13103)

T1.2.1 Item 13100 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in the patient who is not stabilised where the total attendance time by the supervising medical specialist exceeds 45 minutes.

T1.2.2 Item 13103 covers the supervision in hospital by a medical specialist for the management of dialysis, haemofiltration, haemoperfusion or peritoneal dialysis in a stabilised patient, or in the case of an unstabilised patient, where the total attendance time by the supervising medical specialist does not exceed 45 minutes.

T1.3 Assisted Reproductive Services (Items 13200 - 13221)

T1.3.1 Medicare benefits are not payable in respect of any other item in the Medicare Benefits Schedule (including Pathology) in lieu of or in conjunction with Items 13200 - 13221. Specifically, Medicare benefits are not payable for Items 13200 - 13221 in association with Item 104, 105, 14203, 14206, 35637, 55040 -55043, 55056, 55057 or 73521 - 73525. Items 14203 and 14206 are not payable for artificial insemination.

T1.3.2 A treatment cycle is a series of treatment for the purposes of in vitro fertilisation, gamete intrafallopian transfer or similar procedures and is defined as beginning either on the day on which treatment by superovulatory drugs is commenced or on the first day of the patient's menstrual cycle, and ending not more than 30 days later.

T1.3.3 Benefits are only payable for treatment cycles beginning on or after 1 November 1990.

T1.3.4 The date of service in respect of treatment covered by Items 13200, 13203, 13206, 13209 and 13218 is deemed to be the first day of the treatment cycle.

T1.3.5 For treatment covered by Items 13200, 13203, 13206 and 13218 the account must be provided by the gynaecologist supervising the treatment cycle.

T1.3.6 Embryology laboratory services covered by Items 13200 and 13206 include egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing. It does not include semen preparation.

T1.3.7 Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

T1.3.8 Items 13200, 13206, 13215 and 13218 do not include services provided in relation to artificial insemination using the husband's or donated sperm.

T1.3.9 Items 13200 and 13203 are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify the Health Insurance Commission of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these two items.

T1.4 Collection of Blood (Item 13709)

T1.4.1 Medicare benefits are payable under Item 13709 for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation.

T1.4.2 Benefits are not payable under Item 13709 for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

T1.5 Intensive Care Management and Procedures (Items 13809-13836)

T1.5.1 'Intensive Care Unit' means a separate hospital area that: (a) is equipped and staffed so as to be capable of providing to a patient: (i) mechanical ventilation for a period of several days; and (ii) invasive cardiovascular monitoring; and (b) is supported by: (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available during normal working hours; and (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and (iii) a registered nurse for at least 18 hours in each day; and (c) has defined admission and discharge policies.

T1.5.2 For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that: (a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child: (i) mechanical ventilation for a period of several days; and (ii) invasive cardiovascular monitoring; and (b) is supported by: (i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available during normal working hours; and (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and (iii) a registered nurse for at least 18 hours in each day; and (c) has defined admission and discharge policies.

T1.5.3 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. However, benefits are also payable for an attendance by another

specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

T1.5.4 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.

T1.5.5 Medicare benefits are payable in respect of 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.

T1.5.6 Benefits are payable for admissions to an Intensive Care Unit following surgery only where clear clinical justification for post-operative intensive care exists.

T1.5.7 In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

(i) all babies weighing less than 1000gms;
(ii) all babies with an endotracheal tube, and for the 24 hours following endotracheal tube removal;
(iii) all babies requiring Constant Positive Airway Pressure (CPAP) for acute respiratory instability;
(iv) all babies requiring more than 40% oxygen for more than 4 hours;
(v) all babies requiring an arterial line for blood gas and pressure monitoring; and
(vi) all babies having frequent seizures.

T1.5.8 Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under Items 13809, 13812, 13819, 13821, 13824, 13833 and 13836.

T1.5.9 Likewise, benefits are not payable under Items 13809, 13812, 13819, 13821, 13824, 13833 and 13836 in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

T1.6 PUVA or UVB Therapy (Items 14050, 14053)

T1.6.1 A component for any necessary subsequent consultation has been included in the Schedule fee for these items. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

RADIATION ONCOLOGY (Group T2)

T2.1 General

T2.1.1 The level of benefits for radiotherapy depends not only on the number of fields irradiated but also on the frequency of irradiation. In the items related to additional fields, it is to be noted that treatment by rotational therapy is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item 15100 plus twice Item 15103.

T2.1.2 Benefits are attracted for an initial referred consultation and radiotherapy treatment where both take place at the same attendance.

T2.2 Planning Services (Items 15500 - 15536)

T2.2.1 A planning episode involves field setting (ie simulation or localisation) and dosimetry (either using a CT interfacing planning computer or a non-CT interfacing planning computer). One plan only will attract Medicare benefits in a course of treatment. However, where a plan for brachytherapy is undertaken in association with a plan for megavoltage or teletherapy treatment, benefits would be attracted for both services.

T2.2.2 Medicare benefits are also payable, under the appropriate radiology item in Group I3, in respect of verification films (or port films) taken during the course of treatment. Benefits are not, however, payable for a consultation rendered in association with a radiotherapy planning service.

OBSTETRICS (Group T4)

T4.1 General

T4.1.1 Where the medical practitioner undertakes the antenatal care, confinement and postnatal care, Items 16516/16517 are appropriate. Items 16500, 16503 or 16506/16507 apply only where the medical practitioner has not provided all three services.

T4.2 Antenatal Care

T4.2.1 The following services where rendered during the antenatal period also attract benefits:-

(a) Items 16523, 16526, 16529, 16532 (when the treatment is given in a hospital or nursing home), 16535/16536, 16539, 16542 (but not normally before the 24th week of pregnancy), 16549, 16552, 16555, 16558 and 16561.

(b) The initial consultation at which pregnancy is diagnosed.
(c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
(d) All other services, excluding those in Category 1 and Group T4 of Category 3 not mentioned above.
(e) Treatment of an intercurrent condition not directly related to the pregnancy.

T4.3 Confinement

T4.3.1 Benefits for the confinement for which there is a component in Items 16506/16507, 16510, 16513 and 16516/16517 also include the following (where indicated) :-

- surgical and/or intravenous infusion induction of labour
- forceps or vacuum extraction
- breech delivery or management of multiple delivery
- evacuation of products of conception by manual removal
- episiotomy or repair of tears
- any service or services covered by Item 16558 or 16561 when performed at time of confinement but not including any other service or services covered by Items 16523 - 16573 in this Group.

T4.3.2 Items 16516/16517 cover delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then item 16520 would be the appropriate item.

T4.3.3 Two items in Group T9 provide benefits for assistance by a medical practitioner at a Caesarean section. The first relates to the instances where the Caesarean section is the only procedure performed, while the second item applies when other operative procedures are performed at the same time.

T4.3.4 As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, benefit would be payable under the appropriate confinement item.

T4.3.5 Where, during the course of a confinement, a medical practitioner hands the patient over to a specialist obstetrician, benefits are payable under Item 16513, in addition to Item 16510 (i.e., confinement as an independent procedure by a specialist). If, at the time of the confinement but before the referring practitioner has undertaken the actual confinement, the specialist is called in for the full management of the confinement, benefits for the referring practitioner's services should be assessed under Items 16500 or 16503 for the antenatal attendances and on a consultation basis for the postnatal attendances.

T4.3.6 It should be noted that, where the antenatal care is shared between two or more practitioners, or where during the course of pregnancy it is necessary for a medical practitioner to hand the patient over to another medical practitioner (e.g., because he goes on leave) benefit is payable once only, and the fee charged is a matter between the doctors and the patient.

T4.3.7 At a high risk delivery benefits will be payable for the attendance of any medical practitioner (called in by the doctor in charge of the delivery) for the purposes of resuscitation and subsequent supervision of the neonate. Examples of high risk deliveries include cases of difficult vaginal delivery, caesarean section or the delivery of babies with Rh problems and babies of toxaemic mothers.

T4.4 Postnatal Care

T4.4.1 The Schedule fees and benefits payable for those items in this Group which include the words, "confinement and postnatal care for nine days", cover all attendances on the mother and the baby during that period, except in the following circumstances:-

(i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion, etc.;
(ii) where the condition of the mother and/or baby during the nine day postnatal period is such as to require the services of another practitioner (e.g., paediatrician, specialist gynaecologist, etc);
(iii) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;
(iv) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

T4.4.2 Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract Medicare benefits.

T4.5 Caesarean Section (Item 16520)

T4.5.1 Benefits under this item are attracted only where the patient has been specifically referred to a specialist, or her care has been transferred to another medical practitioner, for management of the confinement by means of Caesarean section and the practitioner carrying out the procedure has not rendered the antenatal care. Caesarean sections performed in any other circumstances attract benefits under either Item 16516 or Item 16517. (see paragraph T4.3.2 above)

T4.6 Special Services (Items 16523, 16529, 16532, 16555)

T4.6.1 Item 16523 relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

T4.6.2 Items 16529 and 16532 relate to attendances during the antenatal period for treatment which is regarded as not being

part of routine antenatal care.
T4.6.3 Item 16555 relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the confinement.

ASSISTANCE IN THE ADMINISTRATION OF AN ANAESTHETIC (Group T5)

T5.1 General

T5.1.1 A separate benefit is payable under Item 17500 for the services of an assistant anaesthetist in connection with an operation (or combination of operations) for which the number of anaesthetic units is not less than 21 units.
T5.1.2 This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon. Before benefit may be paid for the assistant anaesthetist's services, the names of the surgeon, anaesthetist and assistant anaesthetist must be available.

ANAESTHETICS (Group T6)

T6.1 General

T6.1.1 The Health Insurance Act provides that where an anaesthetic is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of the anaesthetic. The administration of an anaesthetic also includes the pre-operative examination of the patient in preparation for that administration except where such examination entails a separate prior attendance on the patient.
T6.1.2 Each medical service likely to be performed under anaesthesia has been assigned a number of anaesthetic units which reflect the skill and responsibility exercised by the anaesthetist plus the average time taken for each service without regard to the type of anaesthetic agent employed.
T6.1.3 The Schedule fee for the administration of an anaesthetic in connection with a procedure has been derived by applying unit values to the number of anaesthetic units assigned to the procedure. Group T6 of the Schedule lists the item numbers and appropriate anaesthetic units, together with Schedule fees and Medicare benefits. (The appropriate anaesthetic units and item number are also shown below each procedure likely to be performed under anaesthesia).
T6.1.4 An anaesthetic (other than Item 17974 or a dental anaesthetic listed in Subgroup 3) must be administered in connection with another professional service listed in the Schedule (or a prescribed medical service rendered by an approved dental practitioner) if it is to attract benefit. Special provision exists for services not included in the Schedule (see paragraph T6.3).
T6.1.5 Except in special circumstances, benefit is not payable for the administration of an anaesthetic listed in Subgroup 2 unless the anaesthetic is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which the anaesthetic is administered.
T6.1.6 Fees and benefits established for anaesthetic services cover all essential components in the administration of the anaesthetic. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring or estimations of respiratory function by complicated techniques (but not simple techniques covered by Item 11506). It should be noted that extra benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.
T6.1.7 The amount of benefit specified for the administration of an anaesthetic is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Group T5 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon) where the anaesthetic administered by the anaesthetist has an anaesthetic unit value of not less than 21 units.
T6.1.8 Before benefit will be paid for the administration of an anaesthetic, or for the services of an assistant anaesthetist, details of the operation, sufficient to identify it with the appropriate item in the Schedule and the name of the medical practitioner who performed the operation must be shown on the anaesthetist's account in addition to the details set out at paragraph 6.1 of the General Explanatory Notes.
T6.1.9 Where a regional nerve block or field block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthetic item according to the advice in paragraph T6.1.2. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.
T6.1.10 When a regional nerve block or field block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.
T6.1.11 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.
T6.1.12 Before an operation is decided on, a surgeon may refer a patient to a specialist anaesthetist for an opinion as to the patient's fitness to undergo anaesthesia. Such an attendance will attract benefit as follows:-

(i) If, as a result of the consultation, anaesthesia and surgery are proceeded with in the ordinary way, then Item 17603 applies;
(ii) If, as a result of the consultation, surgery is contra-indicated or is postponed for some days or weeks, this consultation, and any subsequent consultation by the anaesthetist during the postponement period, attracts benefits under the appropriate attendance item. In such a case, to qualify for the specialist rate of benefit, the

patient must present a letter or note of referral by the referring doctor.

T6.1.13 It may happen that the professional service for which the anaesthetic is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthetic. Benefit is payable for the anaesthetic administered in connection with such a surgical procedure (or combination of surgical procedures) even though no benefit is payable for the surgical procedure.

T6.1.14 The administration of epidural anaesthesia during labour is covered by Item 18222 or 18225 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner.

T6.2 Multiple Anaesthetic Rule

T6.2.1 The fee for an anaesthetic administered in connection with two or more operations performed on a patient on the one occasion is calculated by the following rule applied to the anaesthetic items for the individual operations:-

100% for the item with the greatest anaesthetic fee
plus 20% for the item with the next greatest anaesthetic fee
plus 10% for each other item.

Note: (a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where the anaesthetic items for two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

(c) The multiple anaesthetic rule also applies to combinations of items in Subgroup 3 (dental anaesthetics) with items in Subgroup 2.

T6.3 Administration of an Anaesthetic for a service not listed in the Schedule (Item 17971).

T6.3.1 This is a non-specific item for the purpose of permitting payment of benefit for an anaesthetic for a professional service not listed in the Schedule or a service in the Schedule which has not been allotted anaesthetic units.

T6.3.2 For the application of this item, see paragraph 10.1 of the General Explanatory Notes.

T6.4 Anaesthetic Services of Unusual Length

T6.4.1 The Medicare Benefits Advisory Committee has formulated principles for the determination of increased Schedule fees in respect of anaesthetic services which are of unusual length.

T6.4.2 These principles are based solely on the unusual length of time involved in the administration of the anaesthetic, rather than considerations of unusual complexity. Applications for increased fees for anaesthetic services of unusual length will, as a general rule, be finalised by Medicare. However, applications relating to anaesthetic services involving unusual complexity should be forwarded, in the usual manner, to the local Medicare office for consideration by the Medicare Benefits Advisory Committee.

T6.4.3 Details of the principles formulated by the Committee and which also apply to dental anaesthetics are:-

A. Single Anaesthetic Services

(i) if the time involved in the administration of the anaesthetic in the particular case does not exceed the usual time allowed in the Medicare Benefits Schedule item for the service (see Explanatory Note (a) below) by more than 2 time units (i.e. 30 minutes) the claim should be disallowed;

(ii) if the claim satisfies the requirements of (i), the benefit may be determined by dividing the total time involved (see Explanatory Note (b) below) into units of 15 minutes and, to the total of these units, adding 4 additional units. Benefit may then be determined by reference to the Schedule item corresponding to the equivalent number of anaesthetic units (see Explanatory Note (c) below).

(iii) if the claim is in respect of an anaesthetic where the time involved is in excess of six hours, the appropriate units should be assessed on a time basis (see Explanatory Note (d) below)

B. Multiple Anaesthetic Services

(i) in relation to prolonged multiple anaesthetic services, where the overall time involved is six (6) hours or more, such services are assessed on a time basis (see Explanatory Note (d) below);

(ii) claims for prolonged multiple anaesthetic services where the time involved is less than six (6) hours should be referred to the local Medicare office for advice on assessment.

Explanatory Notes

(a) The usual time allowed in the Schedule item may be determined by deducting 4 anaesthetic units from the total provided under the Item, and multiplying the resultant number of units by 15 to arrive at the time expressed in minutes.

(b) "Total time involved" is defined as the time in which the anaesthetist is in continuous attendance on the patient and incorporates the supervised period of recovery.

(c) Where the total anaesthetic units derived from the application of the statement of principles produces an anaesthetic unit value which is not currently covered by an item in the Schedule, the procedure to be followed is to take the Schedule item covering the number of anaesthetic units nearest to but **below** the anaesthetic unit value derived and then to add the Schedule item covering the number of anaesthetic units necessary to make up the balance.

(d) In the case of prolonged anaesthetics of more than six hours duration only the initial six hour period is to be calculated using the 15 minute time units. Any time in excess of the first six hours is to be calculated on the basis

that one time unit will be regarded as being 10 minutes rather than 15 minutes.

T6.4.4 In respect of dental anaesthetics it should be noted that the increased benefits for prolonged dental anaesthetics are calculated in the same manner as for other prolonged anaesthetics. The increased benefits may be calculated by reference to the general anaesthetic items, but, should be paid under the appropriate dental anaesthetic items.

T6.5 Appeals

T6.5.1 Appeals against assessments made in accordance with the above principles should be referred through the local Health Insurance Commission office for consideration by the Medicare Benefits Advisory Committee.

T6.6 Anaesthetic Services Associated with MRI (Item 18013)

T6.6.1 Benefits under this item are restricted to anaesthetic services administered in association with magnetic resonance imaging (MRI) services carried out using MRI equipment located at recognised (public) hospitals. (Medicare benefits are not payable for MRI services - see Note DIL. in Category 5).

REGIONAL OR FIELD NERVE BLOCKS (Group T7)

T7.1 General

T7.1.1 A nerve block is interpreted as the anaesthetising of a substantial segment of the body innervated by a large nerve or an area supplied by a smaller nerve where the technique demands expert anatomical knowledge and a high degree of precision.

T7.1.2 Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefit will be paid only under the anaesthetic item relevant to the operation as set out in Group T6.

T7.1.3 Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group T6 anaesthetic item and not the block item in Group T7.

T7.1.4 Where a regional or field nerve block which is covered by an item in Group T7 is administered by a medical practitioner in the course of a surgical procedure undertaken by that practitioner, then such a block will attract benefit under the appropriate Group T7 item.

T7.1.5 When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T7.1.6. Digital ring analgesia, local infiltration into tissue surrounding a lesion or paracervical (uterine) analgesia are not eligible for the payment of Medicare benefits under items within Group T7. Where procedures are carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure.

T7.2 Introduction of a Narcotic (Item 18206)

T7.2.1 Benefits are attracted for this procedure irrespective of the stage of the operation at which the narcotic is introduced.

T7.3 Epidural Injection for Control of Post-operative Pain (Item 18209)

T7.3.1 This item provides benefit for the epidural injection of a local anaesthetic in the caudal, lumbar or thoracic region administered at the end of an operation for the purpose of controlling pain in the post-operative period.

T7.4 Maintenance of Regional or Field Nerve Block (Items 18222 and 18225)

T7.4.1 Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

T7.4.2 When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

SURGICAL OPERATIONS (Group T8)

T8.1 General

T8.1.1 Many items in Group T8 of the Schedule are qualified by one of the following phrases:
"as an independent procedure";
"not being a service associated with a service to which another item in this Group applies"; or
"not being a service to which another item in this Group applies"
An explanation of each of these phrases is as follows.

T8.2 As an Independent Procedure

T8.2.1 The inclusion of this phrase in the description of an item precludes payment of benefits when:-

(i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephropexy (Item 36555) in the course of an open operation on the kidney for another purpose;

(ii) such procedure is combined with another in the same body area, e.g. direct examination of larynx (Item 41846) with another operation on the larnyx or trachea;

(iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item 30067/30068) in conjunction with debridement of deep or extensive contaminated wound of soft

tissue, including suturing of that wound when performed under general anaesthetic (Item 30023).

T8.3 Not Being a Service Associated with a Service to which another Item in this Group Applies

T8.3.1 "Not being a service associated with a service to which another item in this Group applies" means that benefit is not attracted for that item when the service is performed on the same occasion as any other Group T8 service.

T8.4 Not Being a Service to which another Item in this Group Applies

T8.4.1 "Not being a service to which another item in this Group applies" means that this item may be itemised if there is no specific item relating to the service performed, e.g., Items 30387 (Laparotomy involving operation on abdominal viscera (including pelvic viscera), not being a service to which another item in this Group applies). Benefits may be attracted for an item with this qualification as well as benefits for another service during the course of the same operation.

T8.5 Multiple Operation Formula

T8.5.1 The fees for two or more operations, other than amputations, performed on a patient on the one occasion (except as provided in paragraph T8.5.3) are calculated by the following rule:-

100% for the item with the greatest Schedule fee
plus 50% for the item with the next greatest Schedule fee
plus 25% for each other item.

Note:

(a) Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents.

(b) Where two or more operations performed on the one occasion have Schedule fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

T8.5.2 This rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient if the medical practitioner who performed the operation did not also perform or assist at the other operation or any of the other operations, or administer the anaesthetic. In such cases the fees specified in the Schedule apply.

T8.5.3 Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined in paragraph T8.5.1 would apply in respect of the services performed by each medical practitioner. For these purposes the term "operation" includes all items in Group T8 (other than Subgroup 12 of that Group).

T8.5.4 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

T8.5.5 There are a number of items in the Schedule where the description indicates that the item applies only when rendered in association with another procedure. The Schedule fees for such items have therefore been determined on the basis that they would always be subject to the "multiple operation rule".

T8.6 Procedure Performed with Local Infiltration or Digital Block.

T8.6.1 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T8.7 After-care

T8.7.1 As a general rule, the fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided, unless otherwise indicated.

T8.7.2 After-care is deemed to include all post-operative treatment rendered by medical practitioners and need not necessarily be limited to treatment given by the surgeon or to treatment given by any one medical practitioner.

T8.7.3 The amount and duration of after-care consequent on an operation may vary as between patients for the same operation, as well as between different operations which range from minor procedures performed in the medical practitioner's surgery, to major surgery carried out in hospital. As a guide to interpretation, after-care includes all attendances until recovery from the operation (fracture, dislocation etc.) plus the final check or examination, regardless of whether the attendances are at the hospital, rooms, or the patient's home.

T8.7.4 Attendances which form part of after-care, whether at hospitals, rooms, or at patient's home, should not be shown on the doctor's account. When additional services are itemised, the doctor should show against those services on the account the words "not normal after-care", with a brief explanation of the reason for the additional services.

T8.7.5 Subject to the approval of the local Medicare office, benefits may be paid for professional services for the treatment of an intercurrent condition or an unusual complication arising from the operation.

T8.7.6 Some minor operations are merely stages in the treatment of a particular condition. Attendances subsequent to such operations should not be regarded as after-care but rather as a continuation of the treatment of the original condition and attract benefits. Items to which this policy applies are Items 30219, 30222/30223, 32500, 34521, 34524, 38406, 38409, 39015, 41626, 41656, 42614, 42644, 42650 and 47912. 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, 39115, 39118, 39121, 39127, 39130, 39133, 39136, 39324 and 39327.

T8.7.7 Where a patient has been operated on in a recognised hospital as a public patient (as defined in Section 3(i) of the Health Insurance Act), post-operative attendances by a private medical practitioner at a place other than the hospital, attract Medicare benefits on an attendance basis.

T8.7.8 When a surgeon delegates after-care to a local doctor, Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the after-care. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.
T8.7.9 In respect of fractures, where the after-care is delegated to a doctor at a place other than the place where the initial reduction is carried out, benefit may be apportioned on a 50:50 basis rather than on the 75:25 basis suggested for surgical operations.
T8.7.10 Where the reduction of a fracture is carried out by hospital staff in the out-patient or casualty department of a recognised hospital and the patient is then referred to a private practitioner for supervision of the after-care, Medicare benefits are payable for the after-care treatment on an attendance basis.
T8.7.11 The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

Treatment of fracture of	**After-care Period**
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 "
Middle phalanx of finger	6 "
One or more metacarpals not involving base of first carpometacarpal joint	6 "
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 "
Carpus (excluding navicular)	6 "
Navicular or carpal scaphoid	3 months
Colles' fracture of wrist	3 "
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 "
Ulna	8 "
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 "
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 "
Femur	6 "
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 "
More than one phalanx of toe (other than great toe)	6 "
Distal phalanx of great toe	8 "
Proximal phalanx of great toe	8 "
Nasal bones, requiring reduction	4 "
Nasal bones, requiring reduction and involving osteotomies	4 "
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 "
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 "
Maxilla or mandible, external skeletal fixation of	3 "
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord, requiring immobilisation in plaster or traction by skull calipers	6 "
Spine (excluding sacrum), vertebral body, with involvement of cord	6 "

T8.8 Drill Biopsy (Item 30078)
T8.8.1 Needle aspiration biopsy attracts benefit on an attendance basis and not under this item.

T8.9 Lipectomy, Wedge Excision - Two or More Excisions (Item 30171)
T8.9.1 Multiple lipectomies, e.g., both buttocks and both thighs attract benefits under Item 30171 once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction, except in the circumstances outlined in Item 45584.

T8.10 Treatment of Keratoses, Warts etc (Items 30189, 30192, 36815)
T8.10.1 Treatment of keratoses, warts, etc. attract benefits on an attendance basis, with the exception of the treatment of warts in the circumstances outlined in Items 30189, 30192 and 38615.
T8.10.2 The treatment of less than 10 premalignant skin lesions by galvanocautery, electrodesiccation or cryocautery also attracts benefits on an attendance basis.

T8.11 Serial Curettage Excision (Items 30196, 30197)
T8.11.1 Serial curettage excision as opposed to simple curettage refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

T8.12 Telangiectases or Starburst Vessels (Item 30213)
T8.12.1 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).

T8.13 Subcutaneous Mastectomy (Item 30356)
T8.13.1 When, after completing a subcutaneous mastectomy a prosthesis is inserted, benefits are payable for the latter procedure under Item 45527, the multiple operation formula applying.

T8.14 Laparotomy and Other Procedures (Item 30375)
T8.14.1 This item covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

T8.15 Gastrectomy, Sub-total Radical (Item 30523)
T8.15.1 The item differs from total radical Gastrectomy (Item 30524) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

T8.16 Anti-reflux Operations (Items 30527-30533)
T8.16.1 These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item 30387 (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

T8.17 Arterial and Venous Patches (Items 33545-33551, 34815)
T8.17.1 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.
T8.17.2 Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be 34815, 33106 or 34518. If the vein is harvested for the patch through a separate incision, Item 33551 would also apply, in accordance with the multiple operation rule.
T8.17.3 If a patch graft is involved in conjunction with an operative procedure included in Items 33500 - 33542, 33803, 33806, 33815, 33833 or 34142, the patch graft would attract benefits under Item 33545 or 33548 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 33551 would also apply.

T8.18 Colposcopic Examination (Item 35614)
T8.18.1 It should be noted that colposcopic examination (screening) of women during the course of a consultation does not attract Medicare benefits under Item 35614 except in the following circumstances:- (i) where the patient has had an abnormal cervical smear; (ii) where there is a history of ingestion of oestrogen by the patient's mother during her pregnancy; or (iii) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

T8.19 Dilatation of Cervix under General Anaesthesia (Item 35621)
T8.19.1 Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under this item but would be paid under Item 35624 where malignancy is suspected, or otherwise on an attendance basis.

T8.20 Hysteroscopy (Item 35626)
T8.20.1 Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

T8.21 Curettage of Uterus under GA or Major Nerve Block (Items 35639/35640)
T8.21.1 Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item 35624 where malignancy is suspected, or otherwise on an attendance basis.

T8.22 Neoplastic Changes of the Cervix (Items 35644-35648)
T8.22.1 The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

T8.23 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item 35720)
T8.23.1 This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

T8.24 Re-operation via Median Sternotomy (item 38640)
T8.24.1 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.

T8.25 Intradiscal Injection of Chymopapain (Item 40336)
T8.25.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group I3.

T8.26 Meatoplasty (Item 41515)
T8.26.1 When this procedure is associated with Item 41530, 41548, 41557, 41560 or 41563 the multiple operation rule applies.

T8.27 Reconstruction of Auditory Canal (Item 41524)
T8.27.1 When associated with Item 41557, 41560 or 41563 the multiple operation rule applies.

T8.28 Removal of Nasal Polyp or Polypi (Item 41662, 41665/41668)
T8.28.1 Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item 41662. However where the associated procedure is of lesser value than Items 41665/41668, benefit for removal of polypi would be paid under Items 41665/41668.

T8.29 Larynx, Direct Examination (Item 41846)
T8.29.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.30 Microlaryngoscopy (Item 41858)
T8.30.1 This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.31 Refractive Keratoplasty (Item 42671)
T8.31.1 The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42671.

T8.32 Vitrectomy (Items 42719-42731)
T8.32.1 In relation to vitreous surgery the following items would be regarded as intraocular operations and should not be used in combination with Items 42719-42731:

42551 42554 42557 42560 42563 42566 42569 42698 42701 42704 42707 42716
42734 42743 42746 42761 42764 42767 42857

T8.32.2 This list of exclusions was developed following consultation with the Royal Australian College of Ophthalmologists.

T8.33 Readjustment of Adjustable Sutures (Item 42845)
T8.33.1 This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning.

T8.34 Aesthetic Area (Items 45021, 45024)
T8.34.1 For the purposes of items 45021 and 45024 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.

T8.35 Foreign Implant (Item 45051)
T8.35.1 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.

T8.36 Local Skin Flap - Definition
T8.36.1 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 transportation, 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 later procedure will also attract benefit if closed by graft or flap repair but not when closed by

direct suture.
T8.36.2 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.
T8.36.3 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 45200, 45203 or 45206 once only.
T8.36.4 Items where benefit for local skin flap repair (if indicated as above) is payable, include:

30023 30117 30118 30121 30122 30135 30136 30139 30140 30143 30144 30147 30150 30159 30162
30180 30186 30269 37312 45030 45033 45036 45039 45042 45045 45506 45512 45626

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

T8.36.5 The following items are examples of where local flap repair would usually not be payable. If further advice is required the Health Insurance Commission should be contacted.

30026-30049, 30052, 30099-30114, 30125-30132, 30165-30177, 45521, 45524, 45563, 45587, 45632-45644, 45659, 45662, 45677-45713.

T8.37 Augmentation Mammaplasty (Item 45524)
T8.37.1 Medicare benefit is generally not attracted under this item unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast some time after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammaplasty in association with reduction mammaplasty (Item 45521) for correction of breast ptosis.
T8.37.2 Where bilateral mammaplasty is indicated because of disease, trauma or congenital malformation (other than covered under Item 45527), details of such cases including, where possible, colour photographs (frontal and lateral) taken before and after treatment, should be submitted to the local Medicare office for forwarding to the Medicare Benefits Advisory Committee for consideration. The photographs should be forwarded in a sealed envelope marked "Medical - In Confidence".

T8.38 Breast Reconstruction, Myocutaneous Flap (Item 45530)
T8.38.1 When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item 45527, the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item 45545) when performed.
T8.38.2 When a rectus abdominus flap is used, secondary repair of the muscle defect by an external oblique muscle flap would be covered under Item 45012. However, where the repair is by Teflon or similar mesh, Item 30403 should be itemised.

T8.39 Nipple and/or Areola Reconstruction (Item 45545)
T8.39.1 This item involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

T8.40 Liposuction (Item 45584)
T8.40.1 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, 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 taken before and after treatment, 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".

T8.41 Meloplasty for Correction of Facial Asymmetry (Item 45587)
T8.41.1 Benefits are payable under this item for unilateral face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.
T8.41.2 Occasionally bilateral face-lift might be indicated for conditions such as drooling from the angles of the mouth and deep pitting of the skin due to acne scars. Details of such cases including, where possible, colour photographs of the condition taken before and after treatment, 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".

T8.42 Reduction of Eyelids (Items 45617, 45620)
T8.42.1 Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits. Where there is doubt as to whether benefits would be payable, advice should be sought from the local Medicare office.

T8.43 Osteotomy of Jaw (Items 45719 - 45752)

T8.43.1 The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item 47726 or 47729 for the harvesting, plus Item 48239 or 48242 for the grafting.

T8.43.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.44 Genioplasty (Items 45761 and 45764)

T8.44.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.45 Reduction of Dislocation or Fracture

T8.45.1 Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

T8.45.2 Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

T8.45.3 Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

T8.45.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.46 Internal Fixation (Items 48678-48690)

T8.46.1 Benefits under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items 48642 to 48675. The multiple operation rule would apply in each instance.

GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES

SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY

13000	HYPERBARIC OXYGEN THERAPY where the medical practitioner is NOT in the chamber *(See para T1.1 of explanatory notes to this Category)* **Fee:** $98.55 **Benefit:** 75% = $73.95 85% = $83.80
13003	HYPERBARIC OXYGEN THERAPY where the medical practitioner is confined in the chamber *(See para T1.1 of explanatory notes to this Category)* **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45
13006	ADMINISTRATION OF A GENERAL ANAESTHETIC (including the administration of oxygen) during HYPERBARIC THERAPY where the medical practitioner is not confined in the chamber **Fee:** $133.65 **Benefit:** 75% = $100.25 85% = $113.65
13009	ADMINISTRATION OF A GENERAL ANAESTHETIC (including the administration of oxygen) during HYPERBARIC THERAPY where the medical practitioner is confined in the chamber **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
13012	HYPERBARIC TREATMENT including oxygen therapy for a period of more than 2 hours (including examination immediately pre and post treatment) - per hour (Ministerial Determination) **Fee:** $81.85 **Benefit:** 75% = $61.40 85% = $69.60

SUBGROUP 2 - DIALYSIS

13100	SUPERVISION IN HOSPITAL by a medical specialist of - haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $97.35 **Benefit:** 75% = $73.05 85% = $82.75
13103	SUPERVISION IN HOSPITAL by a medical specialist of - haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day *(See para T1.2 of explanatory notes to this Category)* **Fee:** $50.70 **Benefit:** 75% = $38.05 85% = $43.10
13106	DECLOTTING OF AN ARTERIOVENOUS SHUNT **Fee:** $86.50 **Benefit:** 75% = $64.90 85% = $73.55
13109	INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS - INSERTION AND FIXATION OF (AU 8 - 17908) **Fee:** $162.20 **Benefit:** 75% = $121.65 85% = $137.90
13112	PERITONEAL DIALYSIS, establishment of by abdominal puncture and insertion of temporary catheter (including associated consultation) **Fee:** $97.35 **Benefit:** 75% = $73.05 85% = $82.75

SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES

13200	ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures) involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services - but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days - a maximum of 6 claims per patient *(See para T1.3 of explanatory notes to this Category)* **Fee:** $1,582.10 **Benefit:** 75% =$1,186.60 85% =$1,554.40
13203	OVULATION MONITORING SERVICES, for superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies *(See para T1.3 of explanatory notes to this Category)* **Fee:** $395.55 **Benefit:** 75% = $296.70 85% = $367.85
13206	ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphene citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services - but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation - being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies *(See para T1.3 of explanatory notes to this Category)* **Fee:** $678.05 **Benefit:** 75% = $508.55 85% = $650.35
13209 S	PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including in vitro fertilisation, gamete intra-fallopian transfer and similar procedures, or for artificial insemination - payable once only during 1 treatment cycle *(See para T1.3 of explanatory notes to this Category)* **Fee:** $67.80 **Benefit:** 75% = $50.85 85% = $57.65
13212	OOCYTE RETRIEVAL by any means including laparoscopy or ultrasound-guided ova flushing, for the purposes of assisted reproductive technologies including in vitro fertilisation, gamete intra-fallopian transfer or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (AU 9 - 17909) *(See para T1.3 of explanatory notes to this Category)* **Fee:** $288.15 **Benefit:** 75% = $216.15 85% = $260.45
13215	TRANSFER of EMBRYOS or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 applies, being services rendered in 1 treatment cycle (AU 9 - 17909) *(See para T1.3 of explanatory notes to this Category)* **Fee:** $90.40 **Benefit:** 75% = $67.80 85% = $76.85
13218	PREPARATION AND TRANSFER of frozen or donated embryos or both ova and sperm, to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13203, 13206, 13212 or 13215 applies (AU 9 - 17909) *(See para T1.3 of explanatory notes to this Category)* **Fee:** $678.05 **Benefit:** 75% = $508.55 85% = $650.35
13221	PREPARATION OF SEMEN for the purposes of assisted reproductive technologies or for artificial insemination *(See para T1.3 of explanatory notes to this Category)* **Fee:** $41.25 **Benefit:** 75% = $30.95 85% = $35.10

SUBGROUP 4 - PAEDIATRIC & NEONATAL

13300	UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate **Fee:** $40.55 **Benefit:** 75% = $30.45 85% = $34.50

13303	UMBILICAL ARTERY CATHETERISATION with or without infusion **Fee:** $60.15 **Benefit:** 75% = $45.15 85% = $51.15
13306	BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor **Fee:** $237.95 **Benefit:** 75% = $178.50 85% = $210.25
13309	BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected **Fee:** $202.80 **Benefit:** 75% = $152.10 85% = $175.10
13312	BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS **Fee:** $20.30 **Benefit:** 75% = $15.25 85% = $17.30
13315	INTRA-UTERINE FOETAL BLOOD TRANSFUSION using blood already collected, INCLUDING NECESSARY AMNIOCENTESIS **Fee:** $162.00 **Benefit:** 75% = $121.50 85% = $137.70
13318	CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) by open exposure in a person under 12 years of age (AU 12 - 17912) **Fee:** $162.00 **Benefit:** 75% = $121.50 85% = $137.70
	SUBGROUP 5 - CARDIOVASCULAR
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (AU 4 - 17904) **Fee:** $68.95 **Benefit:** 75% = $51.75 85% = $58.65
	SUBGROUP 6 - GASTROENTEROLOGY
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE **Fee:** $128.45 **Benefit:** 75% = $96.35 85% = $109.20
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE **Fee:** $256.85 **Benefit:** 75% = $192.65 85% = $229.15
	SUBGROUP 7 - PERFUSION
13600	PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent **Fee:** $316.10 **Benefit:** 75% = $237.10 85% = $288.40
13603	WHOLE BODY PERFUSION, CARDIAC BY-PASS, using heart-lung machine or equivalent **Fee:** $457.30 **Benefit:** 75% = $343.00 85% = $429.60
13606	INDUCED CONTROLLED HYPOTHERMIA - total body **Fee:** $78.00 **Benefit:** 75% = $58.50 85% = $66.30
	SUBGROUP 8 - HAEMATOLOGY
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (AU 10 - 17910) **Fee:** $237.35 **Benefit:** 75% = $178.05 85% = $209.65
13703	ADMINISTRATION OF BLOOD, including collection from donor **Fee:** $85.05 **Benefit:** 75% = $63.80 85% = $72.30

13706	ADMINISTRATION OF BLOOD or bone marrow already collected **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation *(See para T1.4 of explanatory notes to this Category)* **Fee:** $34.45 **Benefit:** 75% = $25.85 85% = $29.30
	SUBGROUP 9 - INTENSIVE CARE MANAGEMENT AND PROCEDURES
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 *(See para T1.5 of explanatory notes to this Category)* **Fee:** $217.35 **Benefit:** 75% = $163.05 85% = $189.65
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 *(See para T1.5 of explanatory notes to this Category)* **Fee:** $161.75 **Benefit:** 75% = $121.35 85% = $137.50
‡ 13815	CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (AU 6 - 17906) *(See para T1.5 of explanatory notes to this Category)* **Fee:** $60.75 **Benefit:** 75% = $45.60 85% = $51.65
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 *(See para T1.5 of explanatory notes to this Category)* **Fee:** $169.55 **Benefit:** 75% = $127.20 85% = $144.15
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) *(See para T1.5 of explanatory notes to this Category)* **Fee:** $48.50 **Benefit:** 75% = $36.40 85% = $41.25
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 *(See para T1.5 of explanatory notes to this Category)* **Fee:** $157.70 **Benefit:** 75% = $118.30 85% = $134.05
‡ 13824	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by a specialist or consultant physician - not being a service to which item 13821 applies - each day *(See para T1.5 of explanatory notes to this Category)* **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
13827	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices *(See para T1.5 of explanatory notes to this Category)* **Fee:** $131.40 **Benefit:** 75% = $98.55 85% = $111.70
13830	INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day *(See para T1.5 of explanatory notes to this Category)* **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60

13833	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on the first day in an Intensive Care Unit *(See para T1.5 of explanatory notes to this Category)* **Fee:** $97.05 **Benefit:** 75% = $72.80 85% = $82.50
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 *(See para T1.5 of explanatory notes to this Category)* **Fee:** $50.55 **Benefit:** 75% = $37.95 85% = $43.00
	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:** $46.30 **Benefit:** 75% = $34.75 85% = $39.40
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:** $69.75 **Benefit:** 75% = $52.35 85% = $59.30
13921	CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment **Fee:** $78.85 **Benefit:** 75% = $59.15 85% = $67.05
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:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
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:** $60.15 **Benefit:** 75% = $45.15 85% = $51.15
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:** $83.90 **Benefit:** 75% = $62.95 85% = $71.35
13933	CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment **Fee:** $93.00 **Benefit:** 75% = $69.75 85% = $79.05
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:** $60.65 **Benefit:** 75% = $45.50 85% = $51.60
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:** $69.75 **Benefit:** 75% = $52.35 85% = $59.30
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:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE, accessing of **Fee:** $37.40 **Benefit:** 75% = $28.05 85% = $31.80
13948	CYTOTOXIC AGENT, instillation of, into a body cavity **Fee:** $46.50 **Benefit:** 75% = $34.90 85% = $39.55

SUBGROUP 11 - DERMATOLOGY

14050	PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation *(See para T1.6 of explanatory notes to this Category)* **Fee:** $41.75 **Benefit:** 75% = $31.35 85% = $35.50
14053	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation *(See para T1.6 of explanatory notes to this Category)* **Fee:** $41.75 **Benefit:** 75% = $31.35 85% = $35.50
14056	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14059, 14062, 14065, 14068, 14071 and 14074 apply) in any 12 month period - session of at least 30 minutes duration (Ministerial Determination) **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70
14059	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14056, 14062, 14065, 14068, 14071 and 14074 apply) in any 12 month period - session of at least 60 minutes duration (Ministerial Determination) **Fee:** $113.90 **Benefit:** 75% = $85.45 85% = $96.85
14062	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14056, 14059, 14065, 14068, 14071 and 14074 apply) in any 12 month period - session of at least 1 hour and 15 minutes duration (Ministerial Determination) **Fee:** $137.65 **Benefit:** 75% = $103.25 85% = $117.05
14065	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14056, 14059, 14062, 14068, 14071 and 14074 apply) in any 12 month period - session of at least 1 hour and 30 minutes duration (Ministerial Determination) **Fee:** $161.40 **Benefit:** 75% = $121.05 85% = $137.20
14068	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14056, 14059, 14062, 14065, 14071 and 14074 apply) in any 12 month period - session of at least 1 hour and 45 minutes duration (Ministerial Determination) **Fee:** $185.10 **Benefit:** 75% = $138.85 85% = $157.40
14071	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14056, 14059, 14062, 14065, 14068 and 14074 apply) in any 12 month period - session of at least 2 hours duration (Ministerial Determination) **Fee:** $208.85 **Benefit:** 75% = $156.65 85% = $181.15
14074	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of severely disfiguring vascular lesions of the head or neck where the individual abnormal vessels are visible at a distance of 2 metres, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14056, 14059, 14062, 14065, 14068 and 14071 apply) in any 12 month period - session of at least 2 hours and 15 minutes duration (Ministerial Determination) **Fee:** $232.55 **Benefit:** 75% = $174.45 85% = $204.85
14077	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14080, 14083, 14086, 14089, 14092 and 14095 apply) in any 12 month period - session of at least 30 minutes duration (Ministerial Determination) **Fee:** $90.20 **Benefit:** 75% = $67.65 85% = $76.70

14080	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14077, 14083, 14086, 14089, 14092 and 14095 apply) in any 12 month period - session of at least 60 minutes duration (Ministerial Determination) **Fee:** $113.90 **Benefit:** 75% = $85.45 85% = $96.85
14083	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14077, 14080, 14086, 14089, 14092 and 14095 apply) in any 12 month period - session of at least 1 hour and 15 minutes duration (Ministerial Determination) **Fee:** $137.65 **Benefit:** 75% = $103.25 85% = $117.05
14086	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14077, 14080, 14083, 14089, 14092, and 14095 apply) in any 12 month period - session of at least 1 hour and 30 minutes duration (Ministerial Determination) **Fee:** $161.40 **Benefit:** 75% = $121.05 85% = $137.20
14089	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14077, 14080, 14083, 14086, 14092, and 14095 apply) in any 12 month period - session of at least 1 hour and 45 minutes duration (Ministerial Determination) **Fee:** $185.10 **Benefit:** 75% = $138.85 85% = $157.40
14092	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14077, 14080, 14083, 14086, 14089, and 14095 apply) in any 12 month period - session of at least 2 hours duration (Ministerial Determination) **Fee:** $208.85 **Benefit:** 75% = $156.65 85% = $181.15
14095	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600 nanometres in the treatment of port wine stains, including any associated consultation, up to a maximum of 12 sessions (including any sessions to which items 14077, 14080, 14083, 14086, 14089, and 14092 apply) in any 12 month period - session of at least 2 hours and 15 minutes duration (Ministerial Determination) **Fee:** $232.55 **Benefit:** 75% = $174.45 85% = $204.85
	SUBGROUP 12 - OTHER THERAPEUTIC PROCEDURES
14200	GASTRIC LAVAGE in the treatment of ingested poison **Fee:** $42.60 **Benefit:** 75% = $31.95 85% = $36.25
14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture **Fee:** $36.45 **Benefit:** 75% = $27.35 85% = $31.00
14206	HORMONE OR LIVING TISSUE IMPLANTATION - by cannula **Fee:** $25.40 **Benefit:** 75% = $19.05 85% = $21.60
14209	INTRA-ARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent **Fee:** $63.25 **Benefit:** 75% = $47.45 85% = $53.80

	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 1 - SUPERFICIAL
15000	*(Benefits for administration of general anaesthetic for radiotherapy are payable under item 17965)* RADIOTHERAPY, SUPERFICIAL (including treatment with x-rays, radium rays or other radioactive substances), not being a service to which another item in this Group applies - each attendance at which fractionated treatment is given - 1 field **Fee:** $30.25 **Benefit:** 75% = $22.70 85% = $25.75
15003	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for item 15000 plus for each field in excess of 1, an amount of $12.20
15006	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field **Fee:** $67.25 **Benefit:** 75% = $50.45 85% = $57.20
15009	- 2 or more fields up to a maximum of 5 additional fields **Derived Fee:** The fee for Item 15006 plus for each field in excess of 1, an amount of $13.25
15012	RADIOTHERAPY, SUPERFICIAL - each attendance at which treatment is given to an eye **Fee:** $38.05 **Benefit:** 75% = $28.55 85% = $32.35
	SUBGROUP 2 - ORTHOVOLTAGE
15100	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE - each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field **Fee:** $33.95 **Benefit:** 75% = $25.50 85% = $28.90
15103	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15100 plus for each field in excess of 1, an amount of $13.45
15106	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE - each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field **Fee:** $40.10 **Benefit:** 75% = $30.10 85% = $34.10
15109	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15106 plus for each field in excess of 1, an amount of $16.15
15112	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE - attendance at which single dose technique is applied - 1 field **Fee:** $85.60 **Benefit:** 75% = $64.20 85% = $72.80
15115	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for Item 15112 plus for each field in excess of 1, an amount of $33.60
	SUBGROUP 3 - MEGAVOLTAGE
15203	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator - with or without electron facilities - each attendance at which treatment is given - 1 field **Fee:** $33.35 **Benefit:** 75% = $25.05 85% = $28.35
15204	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15203 plus for each field in excess of 1, an amount of $21.20

15207	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10 MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field **Fee:** $33.20 **Benefit:** 75% = $24.90 85% = $28.25
15208	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15207 plus for each field in excess of 1, an amount of $21.20
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit - each attendance at which treatment is given - 1 field **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95
15214	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) **Derived Fee:** The fee for item 15211 plus for each field in excess of 1, an amount of $17.80
	SUBGROUP 4 - BRACHYTHERAPY
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (AU 5 - 17905) **Fee:** $254.25 **Benefit:** 75% = $190.70 85% = $226.55
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half life greater than 115 days using automatic afterloading techniques (AU 5 - 17905) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (AU 5 - 17905) **Fee:** $480.30 **Benefit:** 75% = $360.25 85% = $452.60
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (AU 5 - 17905) **Fee:** $482.05 **Benefit:** 75% = $361.55 85% = $454.35
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (AU 4 - 17904) **Fee:** $237.30 **Benefit:** 75% = $178.00 85% = $209.60
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (AU 4 - 17904) **Fee:** $235.65 **Benefit:** 75% = $176.75 85% = $207.95
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (AU 4 - 17904) **Fee:** $463.35 **Benefit:** 75% = $347.55 85% = $435.65
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (AU 4 - 17904) **Fee:** $465.95 **Benefit:** 75% = $349.50 85% = $438.25
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (AU 5 - 17905) **Fee:** $288.15 **Benefit:** 75% = $216.15 85% = $260.45
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (AU 5 - 17905) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (AU 4 - 17904) **Fee:** $514.20 **Benefit:** 75% = $385.65 85% = $486.50

15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (AU 4 - 17904) **Fee:** $514.15 **Benefit:** 75% = $385.65 85% = $486.45
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (AU 7 - 17907) **Fee:** $559.40 **Benefit:** 75% = $419.55 85% = $531.70
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (AU 7 - 17907) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (AU 6 - 17906) **Fee:** $531.15 **Benefit:** 75% = $398.40 85% = $503.45
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (AU 6 - 17906) **Fee:** $530.25 **Benefit:** 75% = $397.70 85% = $502.55
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (AU 5 - 17905) **Fee:** $480.30 **Benefit:** 75% = $360.25 85% = $452.60
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (AU 5 - 17905) **Fee:** $482.05 **Benefit:** 75% = $361.55 85% = $454.35
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (AU 4 - 17904) **Fee:** $54.25 **Benefit:** 75% = $40.70 85% = $46.15
15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site **Fee:** $135.60 **Benefit:** 75% = $101.70 85% = $115.30
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites **Fee:** $361.65 **Benefit:** 75% = $271.25 85% = $333.95
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 - each attendance **Fee:** $41.55 **Benefit:** 75% = $31.20 85% = $35.35
15351	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface **Fee:** $83.05 **Benefit:** 75% = $62.30 85% = $70.60
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface **Fee:** $100.85 **Benefit:** 75% = $75.65 85% = $85.75
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 - each attendance **Fee:** $28.50 **Benefit:** 75% = $21.40 85% = $24.25

SUBGROUP 5 - COMPUTERISED PLANNING

RADIOTHERAPY PLANNING

15500	RADIATION FIELD SETTING using a simulator or isocentric x-ray or megavoltage machine of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $135.60 **Benefit:** 75% = $101.70 85% = $115.30
15503	RADIATION FIELD SETTING using a simulator or isocentric x-ray or megavoltage machine of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $174.05 **Benefit:** 75% = $130.55 85% = $147.95
15506	RADIATION FIELD SETTING using a simulator or isocentric x-ray or megavoltage machine of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of off-axis fields or several joined fields (not being a service associated with a service to which item 15515 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $259.90 **Benefit:** 75% = $194.95 85% = $232.20
15509	RADIATION FIELD SETTING using a diagnostic x-ray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $117.55 **Benefit:** 75% = $88.20 85% = $99.95
15512	RADIATION FIELD SETTING using a diagnostic x-ray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $151.45 **Benefit:** 75% = $113.60 85% = $128.75
15515	RADIATION FIELD SETTING using a diagnostic x-ray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of off-axis fields or several joined fields (not being a service associated with a service to which item 15506 applies) *(See para T2.2 of explanatory notes to this Category)* **Fee:** $219.25 **Benefit:** 75% = $164.45 85% = $191.55
‡ 15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.2 of explanatory notes to this Category)* **Fee:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55
‡ 15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.2 of explanatory notes to this Category)* **Fee:** $189.85 **Benefit:** 75% = $142.40 85% = $162.15
‡ 15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or off-axis fields, or several joined fields *(See para T2.2 of explanatory notes to this Category)* **Fee:** $356.00 **Benefit:** 75% = $267.00 85% = $328.30
‡ 15527	RADIATION DOSIMETRY by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks *(See para T2.2 of explanatory notes to this Category)* **Fee:** $44.05 **Benefit:** 75% = $33.05 85% = $37.45
‡ 15530	RADIATION DOSIMETRY by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used *(See para T2.2 of explanatory notes to this Category)* **Fee:** $196.65 **Benefit:** 75% = $147.50 85% = $168.95

‡ 15533	RADIATION DOSIMETRY by a non-CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or off-axis fields, or several joined fields *(See para T2.2 of explanatory notes to this Category)* **Fee:** $372.95 **Benefit:** 75% = $279.75 85% = $345.25
† 15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry **Fee:** $190.05 **Benefit:** 75% = $142.55 85% = $162.35

GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE

16000	ADMINISTRATION OF A THERAPEUTIC DOSE OF A RADIOISOTOPE - not being a service to which another item in this Group applies **Fee:** $28.80 **Benefit:** 75% = $21.60 85% = $24.50
16003	INTRA-CAVITARY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 (not including preliminary paracentesis) (AU 5 - 17905) **Fee:** $463.35 **Benefit:** 75% = $347.55 85% = $435.65
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique **Fee:** $356.00 **Benefit:** 75% = $267.00 85% = $328.30
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique **Fee:** $242.95 **Benefit:** 75% = $182.25 85% = $215.25
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 **Fee:** $210.20 **Benefit:** 75% = $157.65 85% = $182.50

GROUP T4 - OBSTETRICS

16500	ANTENATAL CARE (not including any service or services to which item 16516 or 16517 applies) where the attendances do not exceed 10 - each attendance **Fee:** $21.90 **Benefit:** 75% = $16.45 85% = $18.65
16503	ANTENATAL CARE (not including any service or services to which item 16516 or 16517 applies) where attendances exceed 10 **Fee:** $217.20 **Benefit:** 75% = $162.90 85% = $189.50
16506 G 16507 S	CONFINEMENT AND POSTNATAL CARE for 9 days where the medical practitioner has not given the antenatal care **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60 **Fee:** $290.00 **Benefit:** 75% = $217.50 85% = $262.30
16510 S	CONFINEMENT AS AN INDEPENDENT PROCEDURE BY A SPECIALIST in the practice of his or her specialty, where the patient is referred by another medical practitioner including all attendances related to the confinement **Fee:** $246.80 **Benefit:** 75% = $185.10 85% = $219.10
16513	CONFINEMENT, incomplete, with or without postnatal care for 9 days where the patient is referred to a specialist in the practice of his or her specialty or the patient's care is transferred to another medical practitioner for completion of the delivery **Fee:** $113.00 **Benefit:** 75% = $84.75 85% = $96.05
16516 G 16517 S	ANTENATAL CARE, CONFINEMENT with delivery by any means (including Caesarean section) AND POSTNATAL CARE for 9 days **Fee:** $480.30 **Benefit:** 75% = $360.25 85% = $452.60 **Fee:** $621.55 **Benefit:** 75% = $466.20 85% = $593.85
16520	CAESAREAN SECTION and postnatal care for 9 days where the patient has been referred to a specialist in the practice of his or her specialty or the patient's care has been transferred to another medical practitioner for management of the confinement and the practitioner who performs the Caesarean section did not provide the antenatal care *(See para T4.5 of explanatory notes to this Category)* **Fee:** $444.25 **Benefit:** 75% = $333.20 85% = $416.55
16523	TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones - each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance *(See para T4.6 of explanatory notes to this Category)* **Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
16526	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of - each attendance that is not a routine antenatal attendance **Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
16529	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 2 attendances in any 7 day period *(See para T4.6 of explanatory notes to this Category)* **Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
16532	PREGNANCY COMPLICATED BY acute intercurrent infection, intra-uterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day *(See para T4.6 of explanatory notes to this Category)* **Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
16535 G 16536 S	CERVIX, purse string ligation of, for threatened miscarriage (AU 6 - 17906) **Fee:** $117.45 **Benefit:** 75% = $88.10 85% = $99.85 **Fee:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15
16539	CERVIX, removal of purse string ligature of, under general anaesthesia (AU 5 - 17905) **Fee:** $45.25 **Benefit:** 75% = $33.95 85% = $38.50

OBSTETRICS	
16542	PRE-ECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of - each attendance that is not a routine antenatal attendance **Fee:** $15.75 **Benefit:** 75% = $11.85 85% = $13.40
16545 G 16546 S	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60 **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
16549	AMNIOSCOPY OR AMNIOCENTESIS **Fee:** $45.25 **Benefit:** 75% = $33.95 85% = $38.50
16552	CHORIONIC VILLUS SAMPLING including any associated imaging **Fee:** $182.65 **Benefit:** 75% = $137.00 85% = $155.30
16555	ANTENATAL CARDIOTOCOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) *(See para T4.6 of explanatory notes to this Category)* **Fee:** $26.10 **Benefit:** 75% = $19.60 85% = $22.20
16558	VERSION, EXTERNAL, under general anaesthesia, not being a service to which items 16506 to 16517 apply (AU 6 - 17906) **Fee:** $45.25 **Benefit:** 75% = $33.95 85% = $38.50
16561	VERSION, INTERNAL, under general anaesthesia, not being a service to which items 16506 to 16517 apply (AU 6 - 17906) **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
16564	EVACUATION OF PRODUCTS OF CONCEPTION (such as retained foetus, placenta, membranes or mole) by intrauterine manual removal as an independent procedure where the medical practitioner has not managed the confinement, including all associated attendances **Fee:** $123.40 **Benefit:** 75% = $92.55 85% = $104.90
16567	TREATMENT OF POST-PARTUM HAEMORRHAGE by special procedures such as packing of uterus as an independent procedure where the medical practitioner has not managed the confinement, including all associated attendances **Fee:** $123.40 **Benefit:** 75% = $92.55 85% = $104.90
16570	MANIPULATIVE CORRECTION OF ACUTE INVERSION OF UTERUS, by vaginal approach, with or without incision of cervix as an independent procedure where the medical practitioner has not managed the confinement, including all associated attendances **Fee:** $246.80 **Benefit:** 75% = $185.10 85% = $219.10
16573	THIRD DEGREE TEAR, repair of, involving anal sphincter muscles as an independent procedure where the medical practitioner has not managed the confinement, including all associated attendances **Fee:** $185.10 **Benefit:** 75% = $138.85 85% = $157.40

GROUP T5 - ASSISTANCE IN THE ADMINISTRATION OF AN ANAESTHETIC

17500

Assistance in the administration of an anaesthetic for which the anaesthetic unit value is not less than 21 units
Fee: $96.85 **Benefit:** 75% = $72.65 85% = $82.35

GROUP T6 - ANAESTHETICS

SUBGROUP 1 - EXAMINATION BY AN ANAESTHETIST

17600	EXAMINATION OF A PATIENT BY OTHER THAN A SPECIALIST IN THE PRACTICE OF HIS OR HER SPECIALITY IN PREPARATION FOR THE ADMINISTRATION OF AN ANAESTHETIC, being an examination carried out at a place other than an operating theatre or an anaesthetic induction room **Fee:** $22.15 **Benefit:** 75% = $16.65 85% = $18.85
17603	EXAMINATION OF A PATIENT BY A SPECIALIST IN THE PRACTICE OF HIS OR HER SPECIALTY IN PREPARATION FOR THE ADMINISTRATION OF AN ANAESTHETIC, being an examination carried out at a place other than an operating theatre or an anaesthetic induction room **Fee:** $30.50 **Benefit:** 75% = $22.90 85% = $25.95

SUBGROUP 2 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A MEDICAL SERVICE

	ADMINISTRATION OF AN ANAESTHETIC - In connection with a medical service which has been assigned an anaesthetic unit value of
17901	- ONE UNIT **Fee:** $13.05 **Benefit:** 75% = $9.80 85% = $11.10
17902	- TWO UNITS **Fee:** $26.10 **Benefit:** 75% = $19.60 85% = $22.20
17903	- THREE UNITS **Fee:** $39.15 **Benefit:** 75% = $29.40 85% = $33.30
17904	- FOUR UNITS **Fee:** $52.15 **Benefit:** 75% = $39.15 85% = $44.35
17905	- FIVE UNITS **Fee:** $65.20 **Benefit:** 75% = $48.90 85% = $55.45
17906	- SIX UNITS **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
17907	- SEVEN UNITS **Fee:** $91.30 **Benefit:** 75% = $68.50 85% = $77.65
17908	- EIGHT UNITS **Fee:** $104.35 **Benefit:** 75% = $78.30 85% = $88.70
17909	- NINE UNITS **Fee:** $117.40 **Benefit:** 75% = $88.05 85% = $99.80
17910	- TEN UNITS **Fee:** $130.45 **Benefit:** 75% = $97.85 85% = $110.90
17911	- ELEVEN UNITS **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
17912	- TWELVE UNITS **Fee:** $156.50 **Benefit:** 75% = $117.40 85% = $133.05
17913	- THIRTEEN UNITS **Fee:** $169.55 **Benefit:** 75% = $127.20 85% = $144.15

ANAESTHETICS					MEDICAL SERVICE
17914	- FOURTEEN UNITS **Fee:** $182.60	**Benefit:**	75% = $136.95	85% = $155.25	
17915	- FIFTEEN UNITS **Fee:** $195.65	**Benefit:**	75% = $146.75	85% = $167.95	
17916	- SIXTEEN UNITS **Fee:** $208.70	**Benefit:**	75% = $156.55	85% = $181.00	
17917	- SEVENTEEN UNITS **Fee:** $221.75	**Benefit:**	75% = $166.35	85% = $194.05	
17918	- EIGHTEEN UNITS **Fee:** $234.80	**Benefit:**	75% = $176.10	85% = $207.10	
17919	- NINETEEN UNITS **Fee:** $247.80	**Benefit:**	75% = $185.85	85% = $220.10	
17920	- TWENTY UNITS **Fee:** $260.85	**Benefit:**	75% = $195.65	85% = $233.15	
17921	- TWENTY-ONE UNITS **Fee:** $273.90	**Benefit:**	75% = $205.45	85% = $246.20	
17922	- TWENTY-TWO UNITS **Fee:** $286.95	**Benefit:**	75% = $215.25	85% = $259.25	
17923	- TWENTY-THREE UNITS **Fee:** $300.00	**Benefit:**	75% = $225.00	85% = $272.30	
17924	- TWENTY-FOUR UNITS **Fee:** $313.05	**Benefit:**	75% = $234.80	85% = $285.35	
17925	- TWENTY-FIVE UNITS **Fee:** $326.10	**Benefit:**	75% = $244.60	85% = $298.40	
17926	- TWENTY-SIX UNITS **Fee:** $339.10	**Benefit:**	75% = $254.35	85% = $311.40	
17927	- TWENTY-SEVEN UNITS **Fee:** $352.15	**Benefit:**	75% = $264.15	85% = $324.45	
17928	- TWENTY-EIGHT UNITS **Fee:** $365.20	**Benefit:**	75% = $273.90	85% = $337.50	
17929	- TWENTY-NINE UNITS **Fee:** $378.25	**Benefit:**	75% = $283.70	85% = $350.55	
17930	- THIRTY UNITS **Fee:** $391.30	**Benefit:**	75% = $293.50	85% = $363.60	
17931	- THIRTY ONE UNITS **Fee:** $404.35	**Benefit:**	75% = $303.30	85% = $376.65	
17932	- THIRTY-TWO UNITS **Fee:** $417.40	**Benefit:**	75% = $313.05	85% = $389.70	
17933	- THIRTY-THREE UNITS **Fee:** $430.45	**Benefit:**	75% = $322.85	85% = $402.75	
17934	- THIRTY-FOUR UNITS **Fee:** $443.45	**Benefit:**	75% = $332.60	85% = $415.75	
17935	- THIRTY-FIVE UNITS **Fee:** $456.50	**Benefit:**	75% = $342.40	85% = $428.80	

17936	- THIRTY-SIX UNITS **Fee:** $469.55 **Benefit:** 75% = $352.20 85% = $441.85
17938	- THIRTY-EIGHT UNITS **Fee:** $495.65 **Benefit:** 75% = $371.75 85% = $467.95
17939	- THIRTY-NINE UNITS **Fee:** $508.70 **Benefit:** 75% = $381.55 85% = $481.00
17940	- FORTY UNITS **Fee:** $521.75 **Benefit:** 75% = $391.35 85% = $494.05
17942	- FORTY-TWO UNITS **Fee:** $547.80 **Benefit:** 75% = $410.85 85% = $520.10
17944	-FORTY-FOUR UNITS **Fee:** $573.90 **Benefit:** 75% = $430.45 85% = $546.20
17946	- FORTY-SIX UNITS **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $572.30
17947	- FORTY-SEVEN UNITS **Fee:** $613.05 **Benefit:** 75% = $459.80 85% = $585.35
17950	- FIFTY UNITS **Fee:** $652.15 **Benefit:** 75% = $489.15 85% = $624.45
17952	- FIFTY-TWO UNITS **Fee:** $678.25 **Benefit:** 75% = $508.70 85% = $650.55
17958	- FIFTY-EIGHT UNITS **Fee:** $756.50 **Benefit:** 75% = $567.40 85% = $728.80
17959	- FIFTY-NINE UNITS **Fee:** $769.55 **Benefit:** 75% = $577.20 85% = $741.85
17965	- In connection with radiotherapy **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
17968	- In connection with forceps delivery, vacuum extraction delivery, breech delivery by manipulation or rotation of head followed by delivery **Fee:** $91.30 **Benefit:** 75% = $68.50 85% = $77.65
17971	- In connection with a medical service, being a medical service which does not contain a reference to a number of anaesthetic units *(See para T6.3 of explanatory notes to this Category)* **Fee:** $13.05 **Benefit:** 75% = $9.80 85% = $11.10
17974	- Where the anaesthetic is administered as a therapeutic procedure **Fee:** $130.45 **Benefit:** 75% = $97.85 85% = $110.90
17977	- In connection with reamputation of amputation stump referred to in item 44376 **Derived Fee:** 85% of the fee specified for the anaesthetic for the amputation
17980	- In connection with computerised tomography - brain scan with or without contrast medium study **Fee:** $104.35 **Benefit:** 75% = $78.30 85% = $88.70
17983	- In connection with computerised tomography - body scan with or without contrast medium study **Fee:** $104.35 **Benefit:** 75% = $78.30 85% = $88.70
17986	- In connection with the removal of phaeochromocytoma **Fee:** $209.25 **Benefit:** 75% = $156.95 85% = $181.55
17989	- In connection with peripheral venous cannulation **Fee:** $52.30 **Benefit:** 75% = $39.25 85% = $44.50

17992	- In connection with peripheral venous cannulation by open exposure **Fee:** $64.85 **Benefit:** 75% = $48.65 85% = $55.15
17995	- In connection with percutaneous central venous cannulation **Fee:** $64.85 **Benefit:** 75% = $48.65 85% = $55.15
17998	- In connection with electrocochleography (insertion of electrodes and brain stem evoked response audiometry) **Fee:** $143.15 **Benefit:** 75% = $107.40 85% = $121.70
18001	- In connection with manual removal of products of conception, treatment of postpartum haemorrhage or repair of third degree tear **Fee:** $91.30 **Benefit:** 75% = $68.50 85% = $77.65
18004	- In connection with manipulative correction of acute inversion of uterus by vaginal approach **Fee:** $104.35 **Benefit:** 75% = $78.30 85% = $88.70
18007	- In connection with Caesarean section **Fee:** $130.45 **Benefit:** 75% = $97.85 85% = $110.90
18010	- In connection with repair of episiotomy **Fee:** $65.40 **Benefit:** 75% = $49.05 85% = $55.60
18013	- In connection with magnetic resonance imaging services provided at prescribed locations *(See para T6.6 of explanatory notes to this Category)* **Fee:** $142.75 **Benefit:** 75% = $107.10 85% = $121.35
	SUBGROUP 3 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A DENTAL SERVICE
18102	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC in connection with a dental operation other than for teeth extraction or restorative dental work where the procedure is less than 15 minutes duration **Fee:** $51.70 **Benefit:** 75% = $38.80 85% = $43.95
18103	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC in connection with a dental operation other than for teeth extraction or restorative dental work where the procedure is more than 15 minutes duration **Fee:** $91.00 **Benefit:** 75% = $68.25 85% = $77.35
18105	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC for extraction of a tooth or teeth, not being a service to which item 18109 applies **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
18109	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for removal of a tooth or teeth requiring incision of soft tissue and removal of bone **Fee:** $104.35 **Benefit:** 75% = $78.30 85% = $88.70
18113	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for restorative dental work where the procedure is of not more than 30 minutes duration **Fee:** $78.25 **Benefit:** 75% = $58.70 85% = $66.55
18118	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for restorative dental work where the procedure is of more than 30 minutes duration **Fee:** $130.45 **Benefit:** 75% = $97.85 85% = $110.90

GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS

(Note: Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid under the anaesthetic item relevant to the operation. Additional benefits are not payable under an item in this Group other than for items 18206 or 18209)

18206 INTRODUCTION OF A NARCOTIC, for the control of post-operative pain, into the epidural or intrathecal space in conjunction with an operation
(See para T7.2 of explanatory notes to this Category)
Fee: $35.75 **Benefit:** 75% = $26.85 85% = $30.40

18209 INTRODUCTION at the end of an operation of a local anaesthetic into the caudal, lumbar or thoracic epidural space for the control of post-operative pain, in conjunction with general anaesthesia
(See para T7.3 of explanatory notes to this Category)
Fee: $35.65 **Benefit:** 75% = $26.75 85% = $30.35

* 18213 INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion
Fee: $63.20 **Benefit:** 75% = $47.40 85% = $53.75

† 18216 INTRATHECAL, EPIDURAL OR CAUDAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner
Fee: $75.80 **Benefit:** 75% = $56.85 85% = $64.45

† 18219 INTRATHECAL, EPIDURAL OR CAUDAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour
Derived Fee: The fee for item 18216 plus $13.15 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner

† 18222 INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less
(See para T7.4 of explanatory notes to this Category)
Fee: $26.80 **Benefit:** 75% = $20.10 85% = $22.80

† 18225 INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes
(See para T7.4 of explanatory notes to this Category)
Fee: $35.90 **Benefit:** 75% = $26.95 85% = $30.55

† 18228 INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance
Fee: $44.50 **Benefit:** 75% = $33.40 85% = $37.85

† 18230 INTRATHECAL, EPIDURAL OR CAUDAL INJECTION of neurolytic substance
Fee: $169.85 **Benefit:** 75% = $127.40 85% = $144.40

† 18232 INTRATHECAL, EPIDURAL OR CAUDAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies
Fee: $71.75 **Benefit:** 75% = $53.85 85% = $61.00

† 18233 EPIDURAL INJECTION of blood for blood patch
Fee: $71.75 **Benefit:** 75% = $53.85 85% = $61.00

† 18234 TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent
Fee: $88.95 **Benefit:** 75% = $66.75 85% = $75.65

† 18236 TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent
Fee: $44.50 **Benefit:** 75% = $33.40 85% = $37.85

† 18238 FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies
Fee: $26.80 **Benefit:** 75% = $20.10 85% = $22.80

REGIONAL OR FIELD NERVE BLOCKS	
† 18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent **Fee:** $66.70 **Benefit:** 75% = $50.05 85% = $56.70
† 18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent **Fee:** $26.80 **Benefit:** 75% = $20.10 85% = $22.80
† 18244	VAGUS NERVE, injection of an anaesthetic agent **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00
† 18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00
† 18248	PHRENIC NERVE, injection of an anaesthetic agent **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
† 18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
† 18252	CERVICAL PLEXUS, injection of an anaesthetic agent **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00
† 18254	BRACHIAL PLEXUS, injection of an anaesthetic agent **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00
† 18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
† 18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
† 18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
† 18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
† 18264	PUDENDAL NERVE, injection of an anaesthetic agent **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00
† 18266	ULNAR, RADIAL OR MEDIAN NERVE OF MAIN TRUNK, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
† 18268	OBTURATOR NERVE, injection of an anaesthetic agent **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
† 18270	FEMORAL NERVE, injection of an anaesthetic agent **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
† 18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE OF MAIN TRUNK, 1 or more of, injection of an anaesthetic agent **Fee:** $44.50 **Benefit:** 75% = $33.40 85% = $37.85
† 18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
† 18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) **Fee:** $88.95 **Benefit:** 75% = $66.75 85% = $75.65
† 18278	SCIATIC NERVE, injection of an anaesthetic agent **Fee:** $62.70 **Benefit:** 75% = $47.05 85% = $53.30
† 18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent **Fee:** $88.95 **Benefit:** 75% = $66.75 85% = $75.65

REGIONAL OR FIELD NERVE BLOCKS	
† 18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure **Fee:** $71.75 **Benefit:** 75% = $53.85 85% = $61.00
† 18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) **Fee:** $105.15 **Benefit:** 75% = $78.90 85% = $89.40
† 18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) **Fee:** $105.15 **Benefit:** 75% = $78.90 85% = $89.40
† 18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent **Fee:** $105.15 **Benefit:** 75% = $78.90 85% = $89.40
† 18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent **Fee:** $177.90 **Benefit:** 75% = $133.45 85% = $151.25
† 18292	NERVE BRANCH, not covered by any other item in this Group, destruction by a neurolytic agent **Fee:** $88.95 **Benefit:** 75% = $66.75 85% = $75.65
† 18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent **Fee:** $125.35 **Benefit:** 75% = $94.05 85% = $106.55
† 18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent **Fee:** $107.15 **Benefit:** 75% = $80.40 85% = $91.10
† 18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent **Fee:** $125.35 **Benefit:** 75% = $94.05 85% = $106.55

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

30000	Operative procedure on tissue, organ or region not being a service to which another item in this Group applies, including any consultation on the same occasion **Fee:** $13.10 **Benefit:** 75% = $9.85 85% = $11.15
30003	DRESSING OF LOCALISED BURNS (not involving grafting) - each attendance at which the procedure is performed, including any associated consultation **Fee:** $21.90 **Benefit:** 75% = $16.45 85% = $18.65
30006	DRESSING OF BURNS, EXTENSIVE, without anaesthesia (not involving grafting) - each attendance at which the procedure is performed, including any associated consultation **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15
30009 G 30010 S	DRESSING OF LOCALISED BURNS UNDER GENERAL ANAESTHESIA (not involving grafting) - each attendance at which the procedure is performed, including any associated consultation (AU 7 - 17907) **Fee:** $43.20 **Benefit:** 75% = $32.40 85% = $36.75 **Fee:** $52.65 **Benefit:** 75% = $39.50 85% = $44.80
30013 G 30014 S	DRESSING OF BURNS, EXTENSIVE, UNDER GENERAL ANAESTHESIA (not involving grafting) - each attendance at which the procedure is performed, including any associated consultation (AU 10 - 17910) **Fee:** $93.15 **Benefit:** 75% = $69.90 85% = $79.20 **Fee:** $110.70 **Benefit:** 75% = $83.05 85% = $94.10
30017	EXCISION, under general anaesthesia, OF BURNS involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (AU 10 - 17910) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
30020	EXCISION, under general anaesthesia, OF BURNS involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (AU 15 - 17915) **Fee:** $452.25 **Benefit:** 75% = $339.20 85% = $424.55
30023	DEBRIDEMENT, under general anaesthesia or major regional or field block, of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed (AU 10 - 17910) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, other than on face or neck, small (NOT MORE THAN 7 CENTIMETRES LONG), superficial, not being a service to which another item in Group T4 applies (AU 5 - 17905) **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, other than on face or neck, small (NOT MORE THAN 7 CENTIMETRES LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (AU 6 - 17906) **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55
30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CENTIMETRES LONG), superficial (AU 7 - 17907) **Fee:** $58.75 **Benefit:** 75% = $44.10 85% = $49.95
30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CENTIMETRES LONG), involving deeper tissue (AU 7 - 17907) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15
30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, other than on face or neck, large (MORE THAN 7 CENTIMETRES LONG), superficial, not being a service to which another item in Group T4 applies (AU 6 - 17906) **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55

30041 G 30042 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, other than on face or neck, large (MORE THAN 7 CENTIMETRES LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (AU 7 - 17907) **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25 **Fee:** $130.95 **Benefit:** 75% = $98.25 85% = $111.35
30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CENTIMETRES LONG), superficial (AU 7 - 17907) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15
30048 G 30049 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CENTIMETRES LONG), involving deeper tissue (AU 8 - 17908) **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70 **Fee:** $132.30 **Benefit:** 75% = $99.25 85% = $112.50
30052	REPAIR OF FULL THICKNESS LACERATION OF EAR, EYELID OR NOSE with accurate apposition of each layer of tissue (AU 10 - 17910) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
30055	DRESSING AND REMOVAL OF SUTURES requiring a general anaesthetic, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $52.65 **Benefit:** 75% = $39.50 85% = $44.80
30058	CONTROL OF POST-OPERATIVE HAEMORRHAGE, under general anaesthesia following perineal or vaginal operations (AU 6 - 17906) **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25
30061	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (AU 5 - 17905) **Fee:** $16.75 **Benefit:** 75% = $12.60 85% = $14.25
30064	SUBCUTANEOUS FOREIGN BODY, REMOVAL OF, requiring incision and suture, as an independent procedure (AU 6 - 17906) **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60
30067 G 30068 S	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (AU 7 - 17907) **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45 **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
30071	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (AU 5 - 17905) **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
30074 G 30075 S	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure (AU 6 - 17906) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15 **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70
30078	DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure (AU 5 - 17905) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $34.45 **Benefit:** 75% = $25.85 85% = $29.30
30081	BIOPSY OF BONE MARROW by trephine using open approach (AU 5 - 17905) **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60
30084	BIOPSY OF BONE MARROW by trephine using percutaneous approach with a Jamshidi needle or similar device (AU 5 - 17905) **Fee:** $41.85 **Benefit:** 75% = $31.40 85% = $35.60
30087	BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE (AU 5 - 17905) **Fee:** $21.00 **Benefit:** 75% = $15.75 85% = $17.85
30090	BIOPSY OF PLEURA, PERCUTANEOUS - 1 or more biopsies on any 1 occasion (AU 5 - 17905) **Fee:** $91.55 **Benefit:** 75% = $68.70 85% = $77.85

OPERATIONS		GENERAL
30093	NEEDLE BIOPSY OF VERTEBRA (AU 8 - 17908) **Fee:** $122.15 **Benefit:** 75% = $91.65 85% = $103.85	
30094	PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional techniques - but not including imaging (AU 6 - 17906) **Fee:** $134.95 **Benefit:** 75% = $101.25 85% = $114.75	
30096	SCALENE NODE BIOPSY (AU 5 - 17905) **Fee:** $130.95 **Benefit:** 75% = $98.25 85% = $111.35	
30099	SINUS, excision of, involving superficial tissue only (AU 6 - 17906) **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55	
30102 G 30103 S	SINUS, excision of, involving muscle and deep tissue (AU 7 - 17907) **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70 **Fee:** $130.95 **Benefit:** 75% = $98.25 85% = $111.35	
30106 G 30107 S	GANGLION OR SMALL BURSA, excision of (AU 6 - 17906) **Fee:** $110.70 **Benefit:** 75% = $83.05 85% = $94.10 **Fee:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15	
30110 G 30111 S	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (AU 6 - 17906) **Fee:** $202.50 **Benefit:** 75% = $151.90 85% = $174.80 **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90	
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (AU 7 - 17907) **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90	
30117 G 30118 S	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 30121/30122, 30125/30126, 30129, 30132 or 30195 applies (AU 6 - 17906) **Fee:** $68.85 **Benefit:** 75% = $51.65 85% = $58.55 **Fee:** $90.45 **Benefit:** 75% = $67.85 85% = $76.90	
30121 G 30122 S	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on MORE THAN 3 BUT NOT MORE THAN 10 LESIONS, not being a service to which item 30195 applies (AU 9 - 17909) **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80 **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50	
30125 G 30126 S	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on MORE THAN 10 BUT NOT MORE THAN 20 LESIONS, not being a service to which item 30195 applies (AU 13 - 17913) **Fee:** $240.30 **Benefit:** 75% = $180.25 85% = $212.60 **Fee:** $290.25 **Benefit:** 75% = $217.70 85% = $262.55	
30129	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on MORE THAN 20 BUT NOT MORE THAN 50 LESIONS, not being a service to which item 30195 applies (AU 15 - 17915) **Fee:** $357.75 **Benefit:** 75% = $268.35 85% = $330.05	
30132	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on MORE THAN 50 LESIONS, not being a service to which item 30195 applies (AU 17 - 17917) **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05	
30135 G 30136 S	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (AU 6 - 17906) **Fee:** $101.25 **Benefit:** 75% = $75.95 85% = $86.10 **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45	

30139 G 30140 S	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in this Group applies, involving muscle, bone or other deep tissue (AU 8 - 17908) **Fee:** $140.40 **Benefit:** 75% = $105.30 85% = $119.35 **Fee:** $175.50 **Benefit:** 75% = $131.65 85% = $149.20
30143 G 30144 S	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment), removal of, requiring wide excision, not being a service to which another item in this Group applies (AU 8 - 17908) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50 **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90
30147	MALIGNANT TUMOUR, removal of, from skin, requiring wide and deep excision, other than removal of basal cell carcinoma (AU 8 - 17908) **Fee:** $283.50 **Benefit:** 75% = $212.65 85% = $255.80
30150	MALIGNANT TUMOUR, removal of, from skin, requiring wide and deep excision with immediate block dissection of lymph glands (AU 13 - 17913) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
30153	TUMOUR, removal of, from SOFT TISSUE (INCLUDING MUSCLE, FASCIA AND CONNECTIVE TISSUE), EXTENSIVE EXCISION OF, WITHOUT SKIN GRAFT (AU 8 - 17908) **Fee:** $357.75 **Benefit:** 75% = $268.35 85% = $330.05
30156	TUMOUR, removal of, from SOFT TISSUE (INCLUDING MUSCLE, FASCIA AND CONNECTIVE TISSUE), EXTENSIVE EXCISION OF, WITH SKIN GRAFT (AU 10 - 17910) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
30159	MALIGNANT TUMOUR, removal of, from any region involving a RADICAL OPERATION (not being an operation to which another item in this Group applies) (AU 13 - 17913) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
30162	MALIGNANT TUMOUR, removal of, from any region involving a LIMITED OPERATION, other than removal of basal cell carcinoma (not being an operation to which another item in this Group applies) (AU 8 - 17908) **Fee:** $283.50 **Benefit:** 75% = $212.65 85% = $255.80
30165	LIPECTOMY - transverse wedge excision of abdominal apron (AU 10 - 17910) **Fee:** $324.00 **Benefit:** 75% = $243.00 85% = $296.30
30168	LIPECTOMY - wedge excision of skin or fat not being a service to which item 30165 applies - 1 EXCISION (AU 10 - 17910) **Fee:** $324.00 **Benefit:** 75% = $243.00 85% = $296.30
30171	LIPECTOMY - wedge excision of skin or fat not being a service to which item 30165 applies - 2 OR MORE EXCISIONS (AU 12 - 17912) *(See para T8.9 of explanatory notes to this Category)* **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05
30174	LIPECTOMY - subumbilical excision with undermining of skin edges and strengthening of musculo-aponeurotic wall (AU 12 - 17912) **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05
30177	LIPECTOMY - radical abdominoplasty (Pitanguy type or similar) with excision of skin and subcutaneous tissue, repair of musculo-aponeurotic layer and transposition of umbilicus (AU 18 - 17918) **Fee:** $702.05 **Benefit:** 75% = $526.55 85% = $674.35
30180	AXILLARY HYPERHIDROSIS, wedge excision for (AU 7 - 17907) **Fee:** $97.20 **Benefit:** 75% = $72.90 85% = $82.65
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (AU 10 - 17910) **Fee:** $174.75 **Benefit:** 75% = $131.10 85% = $148.55
30186	PLANTAR WART, removal of (AU 5 - 17905) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70

30189	WARTS or MOLLUSCUM CONTAGIOSUM, removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital or approved day hospital facility, not being a service associated with a service to which another item in this Group applies (AU 6 - 17906) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $104.90 **Benefit:** 75% = $78.70 85% = $89.20
30192	PREMALIGNANT SKIN LESIONS, treatment of, by galvanocautery or electrodesiccation or cryocautery (10 or more lesions) (AU 4 - 17904) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $28.25 **Benefit:** 75% = $21.20 85% = $24.05
‡ 30195	NEOPLASTIC SKIN LESIONS, other than viral verrucae (common warts) and seborrheic keratoses, treatment by electrosurgical destruction, simple curettage or shave excision, not being a service associated with a service to which item 30196, 30197, 30202, 30203 or 30205 applies - (1 or more lesions) (AU 4 - 17904) **Fee:** $45.25 **Benefit:** 75% = $33.95 85% = $38.50
† 30196	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by a specialist opinion, removal of, BY SERIAL CURETTAGE, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies *(See para T8.11 of explanatory notes to this Category)* **Fee:** $89.95 **Benefit:** 75% = $67.50 85% = $76.50
† 30197	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by a specialist opinion, removal of, BY SERIAL CURETTAGE, including any associated cryotherapy or diathermy, (10 OR MORE LESIONS) *(See para T8.11 of explanatory notes to this Category)* **Fee:** $313.40 **Benefit:** 75% = $235.05 85% = $285.70
† 30202	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by a specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies **Fee:** $34.35 **Benefit:** 75% = $25.80 85% = $29.20
† 30203	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by a specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15
† 30205	CANCER OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE CANCER EXTENDS INTO CARTILAGE **Fee:** $89.95 **Benefit:** 75% = $67.50 85% = $76.50
30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations **Fee:** $31.75 **Benefit:** 75% = $23.85 85% = $27.00
30210	KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 5 - 17905) **Fee:** $116.10 **Benefit:** 75% = $87.10 85% = $98.70
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 *(See para T8.12 of explanatory notes to this Category)* **Fee:** $78.20 **Benefit:** 75% = $58.65 85% = $66.50
30216	HAEMATOMA, aspiration of (AU 4 - 17904) **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring a general anaesthetic, INCISION WITH DRAINAGE OF (excluding after-care) **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
30222 G 30223 S	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion requiring a general anaesthetic, INCISION WITH DRAINAGE OF (excluding after-care) (AU 5 - 17905) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15 **Fee:** $116.10 **Benefit:** 75% = $87.10 85% = $98.70

30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional techniques -but not including imaging (AU 7 - 17907) **Fee:** $169.25 **Benefit:** 75% = $126.95 85% = $143.90
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional techniques - but not including imaging (AU 5 - 17905) **Fee:** $190.65 **Benefit:** 75% = $143.00 85% = $162.95
30226	MUSCLE, excision of (LIMITED), or fasciotomy (AU 6 - 17906) **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70
30229	MUSCLE, excision of (EXTENSIVE) (AU 7 - 17907) **Fee:** $194.40 **Benefit:** 75% = $145.80 85% = $166.70
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (AU 7 - 17907) **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (AU 7 - 17907) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (AU 7 - 17907) **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (AU 7 - 17907) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (AU 7 - 17907) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
30247	PAROTID GLAND, total extirpation of (AU 15 - 17915) **Fee:** $526.50 **Benefit:** 75% = $394.90 85% = $498.80
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (AU 18 - 17918) **Fee:** $891.05 **Benefit:** 75% = $668.30 85% = $863.35
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OR REMOVAL OF TUMOUR FROM, with exposure of facial nerve (AU 14 - 17914) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
30256	SUBMANDIBULAR GLAND, extirpation of (AU 8 - 17908) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
30259	SUBLINGUAL GLAND, extirpation of (AU 7 - 17907) **Fee:** $140.40 **Benefit:** 75% = $105.30 85% = $119.35
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (AU 6 - 17906) **Fee:** $41.85 **Benefit:** 75% = $31.40 85% = $35.60
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (AU 7 - 17907) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15 **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (AU 7 - 17907) **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70
30272	TONGUE, partial excision of (AU 7 - 17907) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
30275	RADICAL EXCISION OF INTRA-ORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commando-type operation) (AU 18 - 17918) **Fee:** $1,255.55 **Benefit:** 75% = $941.70 85% =$1,227.85
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (AU 6 - 17906) **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15

30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged not less than 2 years, under general anaesthesia (AU 6 - 17906) **Fee:** $85.05 **Benefit:** 75% = $63.80 85% = $72.30
30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (AU 9 - 17909) **Fee:** $110.70 **Benefit:** 75% = $83.05 85% = $94.10 **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95
30286	BRANCHIAL CYST, removal of (AU 9 - 17909) **Fee:** $283.50 **Benefit:** 75% = $212.65 85% = $255.80
30289	BRANCHIAL FISTULA, removal of (AU 9 - 17909) **Fee:** $357.75 **Benefit:** 75% = $268.35 85% = $330.05
30292	CYSTIC HYGROMA, removal of massive lesion requiring extensive excision - with or without thoracotomy (AU 11 - 17911) **Fee:** $681.80 **Benefit:** 75% = $511.35 85% = $654.10
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (AU 13 - 17913) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (AU 22 - 17922) **Fee:** $1,255.55 **Benefit:** 75% = $941.70 85% =$1,227.85
30296	THYROIDECTOMY, total (AU 14 - 17914) **Fee:** $729.15 **Benefit:** 75% = $546.90 85% = $701.45
30297	THYROIDECTOMY following previous thyroid surgery (AU 14 - 17914) **Fee:** $729.15 **Benefit:** 75% = $546.90 85% = $701.45
30306	TOTAL HEMITHYROIDECTOMY (AU 12 - 17912) **Fee:** $568.85 **Benefit:** 75% = $426.65 85% = $541.15
30308	BILATERAL SUBTOTAL THYROIDECTOMY (AU 12 - 17912) **Fee:** $568.85 **Benefit:** 75% = $426.65 85% = $541.15
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (AU 14 - 17914) **Fee:** $729.15 **Benefit:** 75% = $546.90 85% = $701.45
30310	THYROID, unilateral sub-total thyroidectomy or equivalent partial thyroidectomy (AU 10 - 17910) **Fee:** $325.80 **Benefit:** 75% = $244.35 85% = $298.10
30313	THYROGLOSSAL CYST, removal of (AU 10 - 17910) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (AU 10 - 17910) **Fee:** $325.80 **Benefit:** 75% = $244.35 85% = $298.10
30315	PARATHYROID operation for hyperparathyroidism (AU 16 - 17916) **Fee:** $811.90 **Benefit:** 75% = $608.95 85% = $784.20
30317	CERVICAL RE-EXPLORATION for recurrent or persistent hyperparathyroidism (AU 20 - 17920) **Fee:** $972.20 **Benefit:** 75% = $729.15 85% = $944.50
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (AU 15 - 17915) **Fee:** $646.40 **Benefit:** 75% = $484.80 85% = $618.70
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (AU 17 - 17917) **Fee:** $972.20 **Benefit:** 75% = $729.15 85% = $944.50
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (AU 15 - 17915) **Fee:** $646.40 **Benefit:** 75% = $484.80 85% = $618.70

30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (AU 26 - 17926) **Fee:** $972.20 **Benefit:** 75% = $729.15 85% = $944.50
30324	ADRENAL GLAND TUMOUR, excision of (AU 20 - 17920) **Fee:** $972.20 **Benefit:** 75% = $729.15 85% = $944.50
30325	LYMPH GLANDS of NECK, limited excision of (AU 9 - 17909) **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90
30328	LYMPH GLANDS of NECK, radical excision of (AU 20 - 17920) **Fee:** $702.05 **Benefit:** 75% = $526.55 85% = $674.35
30329	LYMPH GLANDS of GROIN, limited excision of (AU 9 - 17909) **Fee:** $175.80 **Benefit:** 75% = $131.85 85% = $149.45
30330	LYMPH GLANDS of GROIN, radical excision of (AU 13 - 17913) **Fee:** $511.95 **Benefit:** 75% = $384.00 85% = $484.25
30332	LYMPH GLANDS of AXILLA, limited excision of (AU 9 - 17909) **Fee:** $175.80 **Benefit:** 75% = $131.85 85% = $149.45
30333	LYMPH GLANDS of AXILLA, radical excision of (AU 13 - 17913) **Fee:** $511.95 **Benefit:** 75% = $384.00 85% = $484.25
30337 G 30338 S	SIMPLE MASTECTOMY with or without frozen section biopsy (AU 9 - 17909) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50 **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
30341 G 30342 S	BREAST, excision of CYST, fibro adenoma or other local lesion or segmental resection for any other reason (AU 7 - 17907) **Fee:** $140.40 **Benefit:** 75% = $105.30 85% = $119.35 **Fee:** $182.60 **Benefit:** 75% = $136.95 85% = $155.25
30345 G 30346 S	BREAST, excision of CYST, fibro adenoma or other local lesion or segmental resection for any other reason, where frozen section biopsy is performed or where specimen radiography is used (AU 8 - 17908) **Fee:** $186.30 **Benefit:** 75% = $139.75 85% = $158.60 **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
30349 G 30350 S	PARTIAL MASTECTOMY, involving more than 1 quarter of the breast tissue with or without frozen section biopsy (AU 8 - 17908) **Fee:** $186.30 **Benefit:** 75% = $139.75 85% = $158.60 **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
30353	BREAST, extended simple mastectomy with or without frozen section biopsy (AU 12 - 17912) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
30356	SUBCUTANEOUS MASTECTOMY with or without frozen section biopsy (AU 12 - 17912) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $391.50 **Benefit:** 75% = $293.65 85% = $363.80
30359	BREAST, radical or modified radical mastectomy with or without frozen section biopsy (AU 16 - 17916) **Fee:** $614.30 **Benefit:** 75% = $460.75 85% = $586.60
30360	FINE NEEDLE BREAST BIOPSY, imaging guided - but not including imaging (AU 6 - 17906) **Fee:** $134.95 **Benefit:** 75% = $101.25 85% = $114.75
30361	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional techniques - but not including imaging (AU 6 - 17906) **Fee:** $134.95 **Benefit:** 75% = $101.25 85% = $114.75
30363	BREAST, core biopsy of solid tumour or tissue of, using mechanical biopsy device, for histological examination (AU 7 - 17907) **Fee:** $98.25 **Benefit:** 75% = $73.70 85% = $83.55

30364	BREAST, exploration and drainage of haematoma, seroma or inflammatory condition including abscess, granulomatous mastitis or similar, when undertaken in the operating theatre of a hospital or day-hospital facility, excluding aftercare (AU 8 - 17908) **Fee:** $115.85 **Benefit:** 75% = $86.90 85% = $98.50
30366	BREAST, microdochotomy of, for benign or malignant condition (AU 12 - 17912) **Fee:** $237.90 **Benefit:** 75% = $178.45 85% = $210.20
30367	BREAST central ducts, excision of, for benign condition (AU 12 - 17912) **Fee:** $190.30 **Benefit:** 75% = $142.75 85% = $162.60
30369	ACCESSORY BREAST TISSUE, excision of (AU 8 - 17908) **Fee:** $190.30 **Benefit:** 75% = $142.75 85% = $162.60
30370	INVERTED NIPPLE, surgical eversion of (AU 7 - 17907) **Fee:** $107.55 **Benefit:** 75% = $80.70 85% = $91.45
30372	ACCESSORY NIPPLE, excision of (AU 7 - 17907) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (AU 9 - 17909) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $316.55
30375	LAPAROTOMY involving Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (AU 11 - 17911) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intra-abdominal procedure is performed) (AU 14 - 17914) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30378	LAPAROTOMY INVOLVING DIVISION OF ADHESIONS in conjunction with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (AU 14 - 17914) **Fee:** $372.95 **Benefit:** 75% = $279.75 85% = $345.25
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (AU 20 - 17920) **Fee:** $661.10 **Benefit:** 75% = $495.85 85% = $633.40
30381	FAECAL FISTULA, abdominal repair of, by simple excision of bowel (AU 12 - 17912) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
30382	ENTEROCUTANEOUS FISTULA, radical repair of involving extensive dissection and resection of bowel (Ministerial Determination) (AU 16 - 17916) **Fee:** $930.85 **Benefit:** 75% = $698.15 85% = $903.15
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (AU 14 - 17914) **Fee:** $783.05 **Benefit:** 75% = $587.30 85% = $755.35
30385	LAPAROTOMY FOR CONTROL OF POST-OPERATIVE HAEMORRHAGE, where no other procedure is performed (AU 11 - 17911) **Fee:** $401.20 **Benefit:** 75% = $300.90 85% = $373.50
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (AU 12 - 17912) **Fee:** $452.25 **Benefit:** 75% = $339.20 85% = $424.55
30388	LAPAROTOMY for trauma involving 3 or more organs (Ministerial Determination) (AU 24 - 17924) **Fee:** $1,137.70 **Benefit:** 75% = $853.30 85% =$1,110.00

30390	LAPAROSCOPY, diagnostic (AU 7 - 17907) **Fee:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15
30391	LAPAROSCOPY with biopsy (AU 7 - 17907) **Fee:** $202.50 **Benefit:** 75% = $151.90 85% = $174.80
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (AU 10 - 17910) **Fee:** $351.00 **Benefit:** 75% = $263.25 85% = $323.30
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Ministerial Determination) (AU 20 - 17920) **Fee:** $724.00 **Benefit:** 75% = $543.00 85% = $696.30
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Ministerial Determination) (AU 12 - 17912) **Fee:** $165.50 **Benefit:** 75% = $124.15 85% = $140.70
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted(Ministerial Determination) (AU 14 - 17914) **Fee:** $227.55 **Benefit:** 75% = $170.70 85% = $199.85
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (AU 11 - 17911) **Fee:** $450.45 **Benefit:** 75% = $337.85 85% = $422.75
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (AU 9 - 17909) **Fee:** $330.85 **Benefit:** 75% = $248.15 85% = $303.15
30403	VENTRAL, incisional, or recurrent hernia or burst abdomen, repair of (AU 10 - 17910) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30405	VENTRAL, or incisional hernia, repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Ministerial Determination) (AU 16 - 17916) **Fee:** $651.60 **Benefit:** 75% = $488.70 85% = $623.90
30406	PARACENTESIS ABDOMINIS **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
30408	PERITONEO venous (Leveen) shunt, insertion of (Ministerial Determination) (AU 11 - 17911) **Fee:** $279.25 **Benefit:** 75% = $209.45 85% = $251.55
30409	LIVER BIOPSY, percutaneous (AU 6 - 17906) **Fee:** $124.30 **Benefit:** 75% = $93.25 85% = $105.70
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intra-abdominal procedure (AU 11 - 17911) **Fee:** $63.30 **Benefit:** 75% = $47.50 85% = $53.85
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Ministerial Determination) (AU 12 - 17912) **Fee:** $37.25 **Benefit:** 75% = $27.95 85% = $31.70
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Ministerial Determination) (AU 16 - 17916) **Fee:** $491.25 **Benefit:** 75% = $368.45 85% = $463.55
30415	LIVER, segmental resection of, other than for trauma (Ministerial Determination) (AU 18 - 17918) **Fee:** $982.55 **Benefit:** 75% = $736.95 85% = $954.85
30418	LIVER, lobectomy of, other than for trauma (Ministerial Determination) (AU 20 - 17920) **Fee:** $1,137.70 **Benefit:** 75% = $853.30 85% =$1,110.00
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Ministerial Determination) (AU 23 - 17923) **Fee:** $1,422.10 **Benefit:** 75% =$1,066.60 85% =$1,394.40

30422	LIVER, repair of superficial laceration of, for trauma (Ministerial Determination) (AU 12 - 17912) **Fee:** $480.95 **Benefit:** 75% = $360.75 85% = $453.25
30425	LIVER, repair of deep multiple lacerations of, or requiring debridement, for trauma (Ministerial Determination) (AU 18 - 17918) **Fee:** $930.85 **Benefit:** 75% = $698.15 85% = $903.15
30427	LIVER, segmental resection of, for trauma (Ministerial Determination) (AU 18 - 17918) **Fee:** $1,111.80 **Benefit:** 75% = $833.85 85% =$1,084.10
30428	LIVER, lobectomy of, for trauma (Ministerial Determination) (AU 20 - 17920) **Fee:** $1,189.40 **Benefit:** 75% = $892.05 85% =$1,161.70
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Ministerial Determination) (AU 23 - 17923) **Fee:** $1,654.80 **Benefit:** 75% =$1,241.10 85% =$1,627.10
30431	LIVER ABSCESS, open abdominal drainage of (AU 11 - 17911) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Ministerial Determination) (AU 16 - 17916) **Fee:** $517.15 **Benefit:** 75% = $387.90 85% = $489.45
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Ministerial Determination) (AU 14 - 17914) **Fee:** $418.85 **Benefit:** 75% = $314.15 85% = $391.15
30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Ministerial Determination) (AU 16 - 17916) **Fee:** $465.40 **Benefit:** 75% = $349.05 85% = $437.70
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Ministerial Determination) (AU 18 - 17918) **Fee:** $579.20 **Benefit:** 75% = $434.40 85% = $551.50
30439	OPERATIVE CHOLANGIOGRAPHY or operative pancreatography or intra operative ultrasound (including 1 or more examinations performed during the 1 operation) (AU 10 - 17910) **Fee:** $132.30 **Benefit:** 75% = $99.25 85% = $112.50
30440	CHOLANGIOGRAM, percutaneous transhepatic, and biliary drainage, using interventional techniques - but not including imaging (AU 11 - 17911) **Fee:** $374.90 **Benefit:** 75% = $281.20 85% = $347.20
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (AU 7 - 17907) **Fee:** $132.30 **Benefit:** 75% = $99.25 85% = $112.50
30443	CHOLECYSTECTOMY (AU 11 - 17911) **Fee:** $526.50 **Benefit:** 75% = $394.90 85% = $498.80
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Ministerial Determination) (AU 16 - 17916) **Fee:** $579.20 **Benefit:** 75% = $434.40 85% = $551.50
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Ministerial Determination) (AU 17 - 17917) **Fee:** $579.20 **Benefit:** 75% = $434.40 85% = $551.50
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Ministerial Determination) (AU 18 - 17918) **Fee:** $692.95 **Benefit:** 75% = $519.75 85% = $665.25
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Ministerial Determination) (AU 20 - 17920) **Fee:** $770.50 **Benefit:** 75% = $577.90 85% = $742.80
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional techniques - but not including imaging (AU 6 - 17906) **Fee:** $190.65 **Benefit:** 75% = $143.00 85% = $162.95

30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Ministerial Determination) (AU 16 - 17916) **Fee:** $268.90 **Benefit:** 75% = $201.70 85% = $241.20
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (AU 13 - 17913) **Fee:** $614.30 **Benefit:** 75% = $460.75 85% = $586.60
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (AU 18 - 17918) **Fee:** $722.30 **Benefit:** 75% = $541.75 85% = $694.60
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Ministerial Determination) (AU 16 - 17916) **Fee:** $982.55 **Benefit:** 75% = $736.95 85% = $954.85
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (AU 15 - 17915) **Fee:** $722.30 **Benefit:** 75% = $541.75 85% = $694.60
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (AU 15 - 17915) **Fee:** $614.30 **Benefit:** 75% = $460.75 85% = $586.60
30461	RADICAL RESECTION of porta hepatis for gall bladder or common bile duct carcinoma with biliary-enteric anastomoses, not being a service associated with a service to which item 30443, 30454, 30455, 30458 or 30460 applies (AU 19 - 17919) **Fee:** $1,053.05 **Benefit:** 75% = $789.80 85% =$1,025.35
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts for carcinoma, with 2 duct anastomoses (Ministerial Determination) (AU 24 - 17924) **Fee:** $1,292.80 **Benefit:** 75% = $969.60 85% =$1,265.10
30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts for carcinoma, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Ministerial Determination) (AU 30 - 17930) **Fee:** $1,551.40 **Benefit:** 75% =$1,163.55 85% =$1,523.70
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Ministerial Determination) (AU 22 - 17922) **Fee:** $894.65 **Benefit:** 75% = $671.00 85% = $866.95
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Ministerial Determination) (AU 22 - 17922) **Fee:** $1,106.65 **Benefit:** 75% = $830.00 85% =$1,078.95
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Ministerial Determination) (AU 24 - 17924) **Fee:** $1,225.60 **Benefit:** 75% = $919.20 85% =$1,197.90
30470	BILE DUCT FISTULA, repair of, following previous bile duct surgery (Ministerial Determination) (AU 22 - 17922) **Fee:** $775.70 **Benefit:** 75% = $581.80 85% = $748.00
30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to transection of bile duct or ducts (Ministerial Determination) (AU 22 - 17922) **Fee:** $661.90 **Benefit:** 75% = $496.45 85% = $634.20
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (AU 6 - 17906) **Fee:** $140.15 **Benefit:** 75% = $105.15 85% = $119.15
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (AU 7 - 17907) **Fee:** $253.40 **Benefit:** 75% = $190.05 85% = $225.70

30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (AU 7 - 17907) **Fee:** $194.40 **Benefit:** 75% = $145.80 85% = $166.70
30478	OESOPHAGOSCOPY (not being a service to which item 41816, 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastointestional lesions, not being a service associated with a service to which item 30473 or 30476 applies (AU 7 - 17907) **Fee:** $194.40 **Benefit:** 75% = $145.80 85% = $166.70
30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (AU 12 - 17912) **Fee:** $339.05 **Benefit:** 75% = $254.30 85% = $311.35
30481	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (initial procedure) (AU 10 - 17910) **Fee:** $254.25 **Benefit:** 75% = $190.70 85% = $226.55
30482	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (repeat procedure) (AU 10 - 17910) **Fee:** $180.80 **Benefit:** 75% = $135.60 85% = $153.70
30484	ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (AU 8 - 17908) **Fee:** $259.90 **Benefit:** 75% = $194.95 85% = $232.20
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (AU 8 - 17908) **Fee:** $401.20 **Benefit:** 75% = $300.90 85% = $373.50
30487	SMALL BOWEL INTUBATION with biopsy **Fee:** $128.85. **Benefit:** 75% = $96.65 85% = $109.55
30488	SMALL BOWEL INTUBATION - as an independent procedure **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (AU 9 - 17909) **Fee:** $372.95 **Benefit:** 75% = $279.75 85% = $345.25
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (AU 11 - 17911) **Fee:** $395.55 **Benefit:** 75% = $296.70 85% = $367.85
30493	BILIARY MANOMETRY (AU 9 - 17909) **Fee:** $237.30 **Benefit:** 75% = $178.00 85% = $209.60
30494	ENDOSCOPIC BILIARY DILATATION (AU 11 - 17911) **Fee:** $299.45 **Benefit:** 75% = $224.60 85% = $271.75
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (AU 11 - 17911) **Fee:** $418.85 **Benefit:** 75% = $314.15 85% = $391.15
30497	VAGOTOMY and ANTRECTOMY (AU 12 - 17912) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
30499	VAGOTOMY, highly selective (AU 13 - 17913) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (AU 15 - 17915) **Fee:** $636.05 **Benefit:** 75% = $477.05 85% = $608.35
30502	VAGOTOMY, highly selective, with dilatation of pylorus (AU 13 - 17913) **Fee:** $702.05 **Benefit:** 75% = $526.55 85% = $674.35
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (AU 11 - 17911) **Fee:** $786.05 **Benefit:** 75% = $589.55 85% = $758.35
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (AU 11 - 17911) **Fee:** $393.00 **Benefit:** 75% = $294.75 85% = $365.30

30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (AU 13 - 17913) **Fee:** $687.80 **Benefit:** 75% = $515.85 85% = $660.10
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (AU 13 - 17913) **Fee:** $724.00 **Benefit:** 75% = $543.00 85% = $696.30
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (AU 13 - 17913) **Fee:** $724.00 **Benefit:** 75% = $543.00 85% = $696.30
30511	MORBID OBESITY, gastric reduction or gastroplasty for, by any method (AU 13 - 17913) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $577.35
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (AU 21 - 17921) **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
30514	MORBID OBESITY, surgical reversal of procedure to which item 30511 or 30512 applies (AU 22 - 17922) **Fee:** $1,096.30 **Benefit:** 75% = $822.25 85% =$1,068.60
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (AU 12 - 17912) **Fee:** $501.60 **Benefit:** 75% = $376.20 85% = $473.90
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (AU 14 - 17914) **Fee:** $656.75 **Benefit:** 75% = $492.60 85% = $629.05
30518	PARTIAL GASTRECTOMY (AU 15 - 17915) **Fee:** $703.30 **Benefit:** 75% = $527.50 85% = $675.60
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (AU 15 - 17915) **Fee:** $480.95 **Benefit:** 75% = $360.75 85% = $453.25
30521	GASTRECTOMY, TOTAL, for benign disease (AU 19 - 17919) **Fee:** $1,029.10 **Benefit:** 75% = $771.85 85% =$1,001.40
30523	GASTRECTOMY, SUB-TOTAL RADICAL, for carcinoma, (including splenectomy when performed) (AU 19 - 17919) *(See para T8.15 of explanatory notes to this Category)* **Fee:** $1,075.60 **Benefit:** 75% = $806.70 85% =$1,047.90
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (AU 21 - 17921) **Fee:** $1,184.20 **Benefit:** 75% = $888.15 85% =$1,156.50
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaghragmatic hiatus, (including splenectomy when performed) (AU 25 - 17925) **Fee:** $1,535.85 **Benefit:** 75% =$1,151.90 85% =$1,508.15
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus - not being a service to which item 30601 applies (AU 18 - 17918) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $592.85
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (AU 20 - 17920) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $930.85 **Benefit:** 75% = $698.15 85% = $903.15
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (AU 20 - 17920) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $558.50 **Benefit:** 75% = $418.90 85% = $530.80
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus (AU 17 - 17917) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $641.30 **Benefit:** 75% = $481.00 85% = $613.60

30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus (AU 18 - 17918) *(See para T8.16 of explanatory notes to this Category)* **Fee:** $762.80 **Benefit:** 75% = $572.10 85% = $735.10
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (AU 27 - 17927) **Fee:** $1,208.30 **Benefit:** 75% = $906.25 85% =$1,180.60
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck - 1 surgeon (AU 31 - 17931) **Fee:** $1,225.60 **Benefit:** 75% = $919.20 85% =$1,197.90
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck - conjoint surgery, principal surgeon (including aftercare) (AU 31 - 17931) **Fee:** $848.10 **Benefit:** 75% = $636.10 85% = $820.40
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck - conjoint surgery, co-surgeon **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $592.85
30541	OESOPHAGECTOMY, by transhiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (AU 31 - 17931) **Fee:** $1,080.80 **Benefit:** 75% = $810.60 85% =$1,053.10
30542	OESOPHAGECTOMY, by transhiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (AU 31 - 17931) **Fee:** $734.30 **Benefit:** 75% = $550.75 85% = $706.60
30544	OESOPHAGECTOMY, by transhiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon **Fee:** $537.80 **Benefit:** 75% = $403.35 85% = $510.10
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (AU 31 - 17931) **Fee:** $1,308.35 **Benefit:** 75% = $981.30 85% =$1,280.65
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (AU 31 - 17931) **Fee:** $899.80 **Benefit:** 75% = $674.85 85% = $872.10
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon **Fee:** $672.25 **Benefit:** 75% = $504.20 85% = $644.55
30550	OESOPHAGECTMOY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (AU 31 - 17931) **Fee:** $1,468.65 **Benefit:** 75% =$1,101.50 85% =$1,440.95
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (AU 31 - 17931) **Fee:** $1,013.55 **Benefit:** 75% = $760.20 85% = $985.85
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon **Fee:** $749.85 **Benefit:** 75% = $562.40 85% = $722.15
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (AU 31 - 17931) **Fee:** $1,634.10 **Benefit:** 75% =$1,225.60 85% =$1,606.40
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (AU 31 - 17931) **Fee:** $1,127.35 **Benefit:** 75% = $845.55 85% =$1,099.65
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon **Fee:** $832.55 **Benefit:** 75% = $624.45 85% = $804.85

30559	OESOPHAGUS, local excision for tumour of (AU 21 - 17921) **Fee:** $605.05 **Benefit:** 75% = $453.80 85% = $577.35
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (AU 25 - 17925) **Fee:** $672.25 **Benefit:** 75% = $504.20 85% = $644.55
30562	ENTEROSTOMY or COLOSTOMY, closure of - not involving resection of bowel (AU 11 - 17911) **Fee:** $423.80 **Benefit:** 75% = $317.85 85% = $396.10
30563	COLOSTOMY OR ILEOSTOMY, refashioning of (AU 10 - 17910) **Fee:** $423.80 **Benefit:** 75% = $317.85 85% = $396.10
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (AU 17 - 17917) **Fee:** $621.55 **Benefit:** 75% = $466.20 85% = $593.85
30566	SMALL INTESTINE, resection of, with anastomosis (AU 18 - 17918) **Fee:** $689.35 **Benefit:** 75% = $517.05 85% = $661.65
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (AU 8 - 17908) **Fee:** $517.15 **Benefit:** 75% = $387.90 85% = $489.45
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (AU 8 - 17908) **Fee:** $263.75 **Benefit:** 75% = $197.85 85% = $236.05
30571	APPENDICECTOMY, not being a service to which item 30574 applies (AU 8 - 17908) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
30572	LAPAROSCOPIC APPENDICECTOMY (AU 8 - 17908) **Fee:** $341.30 **Benefit:** 75% = $256.00 85% = $313.60
30574	**NOTE:** ***Multiple Operation and Multiple Anaesthetic rules apply to this item*** APPENDICECTOMY, when performed in conjunction with any other intra-abdominal procedure through the same incision (AU 5 - 17905) **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60
30575	PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro pancreatic dissection (AU 11 - 17911) **Fee:** $365.15 **Benefit:** 75% = $273.90 85% = $337.45
30577	PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro pancreatic dissection, excluding aftercare (AU 24 - 17924) **Fee:** $775.70 **Benefit:** 75% = $581.80 85% = $748.00
30578	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (AU 22 - 17922) **Fee:** $817.05 **Benefit:** 75% = $612.80 85% = $789.35
30580	ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (AU 22 - 17922) **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
30581	ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (AU 20 - 17920) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $515.30
30583	DISTAL PANCREATECTOMY (AU 15 - 17915) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
30584	PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (AU 30 - 17930) **Fee:** $1,255.55 **Benefit:** 75% = $941.70 85% =$1,227.85
30586	PANCREATIC CYST - ANASTOMOSIS TO STOMACH OR DUODENUM (AU 13 - 17913) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
30587	PANCREATIC CYST, anastomosis to Roux loop of jejunum (AU 14 - 17914) **Fee:** $517.15 **Benefit:** 75% = $387.90 85% = $489.45

30589	PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (AU 18 - 17918) **Fee:** $891.05 **Benefit:** 75% = $668.30 85% = $863.35
30590	PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (AU 20 - 17920) **Fee:** $982.55 **Benefit:** 75% = $736.95 85% = $954.85
30593	PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (AU 30 - 17930) **Fee:** $1,344.55 **Benefit:** 75% =$1,008.45 85% =$1,316.85
30594	PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (AU 20 - 17920) **Fee:** $1,551.40 **Benefit:** 75% =$1,163.55 85% =$1,523.70
30596	SPLENORRHAPHY OR PARTIAL SPLENECTOMY FOR TRAUMA (AU 13 - 17913) **Fee:** $639.05 **Benefit:** 75% = $479.30 85% = $611.35
30597	SPLENECTOMY (AU 13 - 17913) **Fee:** $513.00 **Benefit:** 75% = $384.75 85% = $485.30
30599	SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (AU 19 - 17919) **Fee:** $930.85 **Benefit:** 75% = $698.15 85% = $903.15
30600	DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (AU 17 - 17917) **Fee:** $553.50 **Benefit:** 75% = $415.15 85% = $525.80
30601	DIAPHRAGMATIC HERNIA, CONGENITAL repair of, by thoracic or abdominal approach (AU 14 - 17914) **Fee:** $681.80 **Benefit:** 75% = $511.35 85% = $654.10
30602	PORTAL HYPERTENSION, porto caval shunt for (AU 24 - 17924) **Fee:** $1,106.65 **Benefit:** 75% = $830.00 85% =$1,078.95
30603	PORTAL HYPERTENSION, meso caval shunt for (AU 24 - 17924) **Fee:** $1,168.70 **Benefit:** 75% = $876.55 85% =$1,141.00
30605	PORTAL HYPERTENSION, selective spleno renal shunt for (AU 24 - 17924) **Fee:** $1,329.00 **Benefit:** 75% = $996.75 85% =$1,301.30
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (AU 18 - 17918) **Fee:** $791.20 **Benefit:** 75% = $593.40 85% = $763.50
† 30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (AU 8 - 17908) **Fee:** $328.55 **Benefit:** 75% = $246.45 85% = $300.85
30612 G 30614 S	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (AU 8 - 17908) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10 **Fee:** $330.75 **Benefit:** 75% = $248.10 85% = $303.05
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (AU 10 - 17910) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30616 G 30617 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (AU 8 - 17908) **Fee:** $189.00 **Benefit:** 75% = $141.75 85% = $161.30 **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
30620 G 30621 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (AU 8 - 17908) **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $185.60 **Fee:** $290.25 **Benefit:** 75% = $217.70 85% = $262.55
30628	HYDROCELE, tapping of **Fee:** $25.40 **Benefit:** 75% = $19.05 85% = $21.60

30631	HYDROCELE, removal of, not being a service associated with a service to which items 30638, 30641 and 30644 apply (AU 7 - 17907) **Fee:** $168.50 **Benefit:** 75% = $126.40 85% = $143.25
30632	PYLOROPLASTY, INFANT, OR PYLOROMYOTOMY (RAMSTEDT'S operation) (AU 9 - 17909) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
30633	INTUSSUSCEPTION, reduction of, by fluid **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
30634 G 30635 S	VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638, 30641 and 30644 apply, 1 procedure (AU 7 - 17907) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30 **Fee:** $207.90 **Benefit:** 75% = $155.95 85% = $180.20
30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (AU 7 - 17907) **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $185.60 **Fee:** $290.25 **Benefit:** 75% = $217.70 85% = $262.55
30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (AU 8 - 17908) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30647	UNDESCENDED TESTIS, orchidopexy or transplantation of, with or without associated hernial repair (AU 8 - 17908) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
30650	SECONDARY DETACHMENT OF TESTIS FROM THIGH (AU 6 - 17906) **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85
30653	CIRCUMCISION of person UNDER 6 MONTHS of age (AU 6 - 17906) **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15
30656	CIRCUMCISION of person UNDER 10 YEARS of age but not less than 6 months of age (AU 6 - 17906) **Fee:** $76.95 **Benefit:** 75% = $57.75 85% = $65.45
30659 G 30660 S	CIRCUMCISION of person 10 YEARS OF AGE OR OVER (AU 6 - 17906) **Fee:** $106.65 **Benefit:** 75% = $80.00 85% = $90.70 **Fee:** $132.30 **Benefit:** 75% = $99.25 85% = $112.50
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (AU 5 - 17905) **Fee:** $102.85 **Benefit:** 75% = $77.15 85% = $87.45
30666	PARAPHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
30672	COCCYX, excision of (AU 8 - 17908) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (AU 8 - 17908) **Fee:** $213.30 **Benefit:** 75% = $160.00 85% = $185.60 **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $242.30
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (AU 6 - 17906) **Fee:** $68.55 **Benefit:** 75% = $51.45 85% = $58.30
31000	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Ministerial Determination) **Fee:** $413.70 **Benefit:** 75% = $310.30 85% = $386.00
31001	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (Ministerial Determination) **Fee:** $517.15 **Benefit:** 75% = $387.90 85% = $489.45

31002	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Ministerial Determination) **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $592.85
	SUBGROUP 2 - COLORECTAL
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (AU 18 - 17918) **Fee:** $734.55 **Benefit:** 75% = $550.95 85% = $706.85
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (AU 20 - 17920) **Fee:** $768.45 **Benefit:** 75% = $576.35 85% = $740.75
‡ 32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000, 32003, 32005 or 32006 applies (AU 20 - 17920) **Fee:** $817.05 **Benefit:** 75% = $612.80 85% = $789.35
‡ 32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (AU 22 - 17922) **Fee:** $925.65 **Benefit:** 75% = $694.25 85% = $897.95
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (AU 20 - 17920) **Fee:** $819.30 **Benefit:** 75% = $614.50 85% = $791.60
32009	TOTAL COLECTOMY AND ILEOSTOMY (AU 22 - 17922) **Fee:** $971.90 **Benefit:** 75% = $728.95 85% = $944.20
32012	TOTAL COLECTOMY AND ILEO-RECTAL ANASTOMOSIS (AU 20 - 17920) **Fee:** $1,073.60 **Benefit:** 75% = $805.20 85% =$1,045.90
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY - 1 surgeon (AU 20 - 17920) **Fee:** $1,324.40 **Benefit:** 75% = $993.30 85% =$1,296.70
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including after-care) (AU 17 - 17917) **Fee:** $1,118.80 **Benefit:** 75% = $839.10 85% =$1,091.10
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION **Fee:** $401.20 **Benefit:** 75% = $300.90 85% = $373.50
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge - excluding resection of sigmoid colon alone (AU 22 - 17922) **Fee:** $971.90 **Benefit:** 75% = $728.95 85% = $944.20
32027	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge (AU 26 - 17926) **Fee:** $1,265.70 **Benefit:** 75% = $949.30 85% =$1,238.00
32030	RECTOSIGMOIDECTOMY - (Hartmann's operation) (AU 15 - 17915) **Fee:** $734.30 **Benefit:** 75% = $550.75 85% = $706.60
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (AU 15 - 17915) **Fee:** $1,073.60 **Benefit:** 75% = $805.20 85% =$1,045.90
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR - excision of (AU 13 - 17913) **Fee:** $1,361.75 **Benefit:** 75% =$1,021.35 85% =$1,334.05
32039	RECTUM AND ANUS, ABDOMINO-PERINEAL RESECTION OF - 1 surgeon (AU 17 - 17917) **Fee:** $1,093.35 **Benefit:** 75% = $820.05 85% =$1,065.65

32042	RECTUM AND ANUS, ABDOMINO-PERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION - abdominal resection (AU 16 - 17916) **Fee:** $921.00 **Benefit:** 75% = $690.75 85% = $893.30
32045	RECTUM AND ANUS, ABDOMINO-PERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION - perineal resection **Fee:** $344.70 **Benefit:** 75% = $258.55 85% = $317.00
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon **Fee:** $532.65 **Benefit:** 75% = $399.50 85% = $504.95
32047	PERINEAL PROCTECTOMY (AU 20 - 17920) **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $592.85
32048	ABDOMINO-PERINEAL PULL THROUGH RESECTION with colo-anal anastomosis (1 or 2 stages), including associated colostomy (AU 30 - 17930) **Fee:** $1,361.75 **Benefit:** 75% =$1,021.35 85% =$1,334.05
32051	TOTAL COLECTOMY WITH EXCISION OF RECTUM and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy - 1 surgeon (AU 36 - 17936) **Fee:** $1,649.95 **Benefit:** 75% =$1,237.50 85% =$1,622.25
32054	TOTAL COLECTOMY WITH EXCISION OF RECTUM and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy - conjoint surgery, abdominal surgeon (including aftercare) (AU 30 - 17930) **Fee:** $1,514.30 **Benefit:** 75% =$1,135.75 85% =$1,486.60
32057	TOTAL COLECTOMY WITH EXCISION OF RECTUM and ileoanal anastomosis with formation of ileal reservoir - conjoint surgery, perineal surgeon **Fee:** $401.20 **Benefit:** 75% = $300.90 85% = $373.50
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy - 1 surgeon (AU 30 - 17930) **Fee:** $1,649.95 **Benefit:** 75% =$1,237.50 85% =$1,622.25
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy - conjoint surgery, abdominal surgeon (including aftercare) (AU 26 - 17926) **Fee:** $1,514.30 **Benefit:** 75% =$1,135.75 85% =$1,486.60
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy - conjoint surgery, perineal surgeon **Fee:** $401.20 **Benefit:** 75% = $300.90 85% = $373.50
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (AU 30 - 17930) **Fee:** $1,220.50 **Benefit:** 75% = $915.40 85% =$1,192.80
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy **Fee:** $37.85 **Benefit:** 75% = $28.40 85% = $32.20
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
32078	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (AU 7 - 17907) **Fee:** $133.35 **Benefit:** 75% = $100.05 85% = $113.35
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (AU 10 - 17910) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (AU 6 - 17906) **Fee:** $88.15 **Benefit:** 75% = $66.15 85% = $74.95

32087	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS - not being a service to which item 32078 applies (AU 10 - 17910) **Fee:** $162.00 **Benefit:** 75% = $121.50 85% = $137.70
32090	FIBREOPTIC COLONOSCOPY - examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (AU 8 - 17908) **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90
32093	FIBREOPTIC COLONOSCOPY - examination of colon beyond the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS (AU 10 - 17910) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
32094	ENDOSCOPIC DILATATION of colorectal strictures including colonoscopy (AU 10 - 17910) **Fee:** $393.00 **Benefit:** 75% = $294.75 85% = $365.30
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (AU 8 - 17908) **Fee:** $91.00 **Benefit:** 75% = $68.25 85% = $77.35
32096	RECTAL BIOPSY, full thickness, under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day-hospital facility (AU 6 - 17906) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
32099	RECTAL TUMOUR of 5 centimetres or less in diameter, per anal submucosal excision of (AU 10 - 17910) **Fee:** $237.30 **Benefit:** 75% = $178.00 85% = $209.60
32102	RECTAL TUMOUR of greater than 5 centimetres in diameter, indicated by pathological examination, per anal submucosal excision of (AU 14 - 17914) **Fee:** $452.05 **Benefit:** 75% = $339.05 85% = $424.35
32105	ANORECTAL CARCINOMA - per anal full thickness excision of (AU 13 - 17913) **Fee:** $344.70 **Benefit:** 75% = $258.55 85% = $317.00
32108	RECTAL TUMOUR, trans-sphincteric excision of (Kraske or similar operation) (AU 13 - 17913) **Fee:** $711.95 **Benefit:** 75% = $534.00 85% = $684.25
32111	RECTAL PROLAPSE - Delorme procedure for (AU 10 - 17910) **Fee:** $452.05 **Benefit:** 75% = $339.05 85% = $424.35
32114	RECTAL STRICTURE, per anal release of (AU 8 - 17908) **Fee:** $124.30 **Benefit:** 75% = $93.25 85% = $105.70
32117	RECTAL PROLAPSE, abdominal repair of (AU 13 - 17913) **Fee:** $711.95 **Benefit:** 75% = $534.00 85% = $684.25
32120	RECTAL PROLAPSE, perineal repair of (AU 6 - 17906) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
32123	ANAL STRICTURE, anoplasty for (AU 7 - 17907) **Fee:** $237.30 **Benefit:** 75% = $178.00 85% = $209.60
32126	ANAL INCONTINENCE, Parks' intersphincteric procedure for (AU 12 - 17912) **Fee:** $344.70 **Benefit:** 75% = $258.55 85% = $317.00
32129	ANAL SPHINCTER, direct repair of (AU 12 - 17912) **Fee:** $452.05 **Benefit:** 75% = $339.05 85% = $424.35
32132	HAEMORRHOIDS OR RECTAL PROLAPSE - sclerotherapy for (AU 6 - 17906) **Fee:** $32.20 **Benefit:** 75% = $24.15 85% = $27.40
32135	HAEMORRHOIDS OR RECTAL PROLAPSE - rubber band ligation of with or without sclerotherapy, cryosurgery or infra red therapy for (AU 5 - 17905) **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85

32138	HAEMORRHOIDECTOMY (AU 8 - 17908) **Fee:** $261.90 **Benefit:** 75% = $196.45 85% = $234.20
32142	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of (AU 7 - 17907) **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
32145	ANAL SKIN TAGS or ANAL POLYPS, excision of 1 or more of, undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 7 - 17907) **Fee:** $96.20 **Benefit:** 75% = $72.15 85% = $81.80
32147	PERIANAL THROMBOSIS, incision of (AU 7 - 17907) **Fee:** $32.20 **Benefit:** 75% = $24.15 85% = $27.40
32150	OPERATION FOR FISSURE-IN-ANO including excision, or sphincterotomy, but excluding dilatation only (AU 6 - 17906) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (AU 4 - 17904) **Fee:** $49.95 **Benefit:** 75% = $37.50 85% = $42.50
32156	FISTULA IN ANO, SUBCUTANEOUS, excision of (AU 7 - 17907) **Fee:** $93.80 **Benefit:** 75% = $70.35 85% = $79.75
32159	ANAL FISTULA, excision of, involving lower half of the anal sphincter mechanism (AU 7 - 17907) **Fee:** $237.30 **Benefit:** 75% = $178.00 85% = $209.60
32162	ANAL FISTULA, excision of, involving the upper half of the anal sphincter mechanism (AU 11 - 17911) **Fee:** $344.70 **Benefit:** 75% = $258.55 85% = $317.00
32165	ANAL FISTULA, repair of, by mucosal flap advancement (AU 15 - 17915) **Fee:** $452.05 **Benefit:** 75% = $339.05 85% = $424.35
32166	ANAL FISTULA - readjustment of Seton (AU 7 - 17907) **Fee:** $146.85 **Benefit:** 75% = $110.15 85% = $124.85
32168	FISTULA WOUND, repair of, under general or regional anaesthetic, as an independent procedure (AU 7 - 17907) **Fee:** $93.80 **Benefit:** 75% = $70.35 85% = $79.75
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (AU 6 - 17906) **Fee:** $63.30 **Benefit:** 75% = $47.50 85% = $53.85
32174	INTRA-ANAL, perianal or ischio-rectal abscess, drainage of (excluding aftercare) (AU 8 - 17908) **Fee:** $63.30 **Benefit:** 75% = $47.50 85% = $53.85
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital or approved day-hospital facility (excluding aftercare) (AU 8 - 17908) **Fee:** $115.85 **Benefit:** 75% = $86.90 85% = $98.50
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (AU 6 - 17906) **Fee:** $124.10 **Benefit:** 75% = $93.10 85% = $105.50
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (AU 11 - 17911) **Fee:** $184.10 **Benefit:** 75% = $138.10 85% = $156.50
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (AU 15 - 17915) **Fee:** $259.90 **Benefit:** 75% = $194.95 85% = $232.20
32186	COLONIC LAVAGE, total, intra operative (AU 12 - 17912) **Fee:** $206.85 **Benefit:** 75% = $155.15 85% = $179.15

SUBGROUP 3 - VASCULAR

VARICOSE VEINS

32500	VARICOSE VEINS, multiple simultaneous injections by continuous compression techniques including associated consultation - 1 OR BOTH LEGS - not being a service associated with any other varicose veins operation on the same leg (excluding after-care) **Fee:** $99.60 **Benefit:** 75% = $74.70 85% = $84.70
32503	VARICOSE VEINS, multiple ligations, with or without local stripping or excision, including sub-fascial ligation of 1 or more deep perforating veins through separate incisions - 1 LEG - not being a service associated with a service to which item 32506, 32509 or 32530 applies on the same leg (AU 7 - 17907) **Fee:** $190.65 **Benefit:** 75% = $143.00 85% = $162.95
32506	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 - 1 leg (AU 10 - 17910) **Fee:** $348.15 **Benefit:** 75% = $261.15 85% = $320.45
32509	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 - 1 leg (AU 12 - 17912) **Fee:** $522.20 **Benefit:** 75% = $391.65 85% = $494.50
32512	LONG SAPHENOUS VEIN, complete dissection and ligation of, at the sapheno-femoral junction, for migrating thrombosis of long saphenous vein (AU 11 - 17911) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30
32515	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 - 1 leg (AU 6 - 17906) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
32518	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 - 1 leg (AU 6 - 17906) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
32521	VARICOSE VEINS, sub-fascial ligation of single deep perforating vein not being a service associated with any other varicose vein operation on the same leg - 1 leg (AU 6 - 17906) **Fee:** $143.55 **Benefit:** 75% = $107.70 85% = $122.05
32524	VARICOSE VEINS, sub-fascial ligation of multiple deep perforating vein - 1 leg (Cockett's operation, Linton's operation or similar procedure) (AU 7 - 17907) **Fee:** $353.50 **Benefit:** 75% = $265.15 85% = $325.80
32527	GROIN OR POPLITEAL FOSSA, reoperation in, for recurrent sapheno-popliteal incompetence - 1 leg (AU 12 - 17912) **Fee:** $428.45 **Benefit:** 75% = $321.35 85% = $400.75
32530	GROIN OR POPLITEAL FOSSA, reoperation in, for recurrent sapheno-femoral incompetence or recurrent sapheno-popliteal incompetence with 1 or more of the following - multiple ligations, local stripping or excision of minor veins or sclerotherapy of minor veins - 1 leg (AU 13 - 17913) **Fee:** $562.35 **Benefit:** 75% = $421.80 85% = $534.65

BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE

32700	ARTERY OF NECK, bypass using vein or synthetic material (AU 19 - 17919) **Fee:** $1,022.95 **Benefit:** 75% = $767.25 85% = $995.25
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (AU 18 - 17918) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55

32706	INTERNAL CAROTID ARTERY, re-operation for recurrent stenosis with bypass by graft of vein or synthetic material (AU 19 - 17919) **Fee:** $1,210.45 **Benefit:** 75% = $907.85 85% =$1,182.75
32709	AORTO-ILIAC OR AORTO-FEMORAL GRAFTING, straight or bifurcated (AU 21 - 17921) **Fee:** $996.20 **Benefit:** 75% = $747.15 85% = $968.50
32712	ILIO-FEMORAL BYPASS GRAFTING (AU 18 - 17918) **Fee:** $894.45 **Benefit:** 75% = $670.85 85% = $866.75
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (AU 19 - 17919) **Fee:** $894.45 **Benefit:** 75% = $670.85 85% = $866.75
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (AU 18 - 17918) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
32721	RENAL ARTERY, bypass grafting to (AU 22 - 17922) **Fee:** $1,344.30 **Benefit:** 75% =$1,008.25 85% =$1,316.60
32724	RENAL ARTERIES (both), bypass grafting to (AU 26 - 17926) **Fee:** $1,526.40 **Benefit:** 75% =$1,144.80 85% =$1,498.70
32727	SPLENO-RENAL ARTERIAL BYPASS GRAFTING (AU 21 - 17921) **Fee:** $1,344.30 **Benefit:** 75% =$1,008.25 85% =$1,316.60
32730	MESENTERIC VESSEL (single), bypass grafting to (AU 18 - 17918) **Fee:** $1,156.85 **Benefit:** 75% = $867.65 85% =$1,129.15
32733	MESENTERIC VESSELS (multiple), bypass grafting to (AU 21 - 17921) **Fee:** $1,344.30 **Benefit:** 75% =$1,008.25 85% =$1,316.60
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (AU 17 - 17917) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (AU 19 - 17919) **Fee:** $921.20 **Benefit:** 75% = $690.90 85% = $893.50
32742	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 - 17920) **Fee:** $1,055.10 **Benefit:** 75% = $791.35 85% =$1,027.40
32745	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 - 17921) **Fee:** $1,205.05 **Benefit:** 75% = $903.80 85% =$1,177.35
32748	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 - 17922) **Fee:** $1,306.85 **Benefit:** 75% = $980.15 85% =$1,279.15
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (AU 18 - 17918) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
32754	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 1 or both anastomoses (AU 20 - 17920) **Fee:** $1,055.10 **Benefit:** 75% = $791.35 85% =$1,027.40
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (AU 16 - 17916) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85

32760	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) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Group applies (AU 18 - 17918) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Group applies, as an independent procedure (AU 15 - 17915) **Fee:** $562.35 **Benefit:** 75% = $421.80 85% = $534.65
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (AU 15 - 17915) **Fee:** $194.95 **Benefit:** 75% = $146.25 85% = $167.25
	BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (AU 20 - 17920) **Fee:** $1,022.95 **Benefit:** 75% = $767.25 85% = $995.25
33103	THORACIC ANEURYSM, replacement by graft (AU 35 - 17935) **Fee:** $1,435.35 **Benefit:** 75% =$1,076.55 85% =$1,407.65
33106	ARTERY OR VEIN BYPASS GRAFT, patch grafting to using vein or synthetic material, not being a service associated with any other vascular operation (AU 14 - 17914) **Fee:** $503.45 **Benefit:** 75% = $377.60 85% = $475.75
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (AU 40 - 17940) **Fee:** $1,735.30 **Benefit:** 75% =$1,301.50 85% =$1,707.60
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (AU 35 - 17935) **Fee:** $1,505.00 **Benefit:** 75% =$1,128.75 85% =$1,477.30
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (AU 26 - 17926) **Fee:** $1,055.10 **Benefit:** 75% = $791.35 85% =$1,027.40
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) (AU 29 - 17929) **Fee:** $1,205.05 **Benefit:** 75% = $903.80 85% =$1,177.35
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (AU 29 - 17929) **Fee:** $1,205.05 **Benefit:** 75% = $903.80 85% =$1,177.35
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (AU 18 - 17918) **Fee:** $862.30 **Benefit:** 75% = $646.75 85% = $834.60
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (AU 20 - 17920) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (AU 18 - 17918) **Fee:** $985.50 **Benefit:** 75% = $739.15 85% = $957.80
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (AU 16 - 17916) **Fee:** $739.10 **Benefit:** 75% = $554.35 85% = $711.40
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (AU 25 - 17925) **Fee:** $1,863.85 **Benefit:** 75% =$1,397.90 85% =$1,836.15
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (AU 19 - 17919) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40

33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (AU 18 - 17918) **Fee:** $1,055.10 **Benefit:** 75% = $791.35 85% =$1,027.40
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (AU 38 - 17938) **Fee:** $1,815.65 **Benefit:** 75% =$1,361.75 85% =$1,787.95
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (AU 40 - 17940) **Fee:** $2,254.80 **Benefit:** 75% =$1,691.10 85% =$2,227.10
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (AU 38 - 17938) **Fee:** $2,142.35 **Benefit:** 75% =$1,606.80 85% =$2,114.65
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (AU 28 - 17928) **Fee:** $1,585.35 **Benefit:** 75% =$1,189.05 85% =$1,557.65
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (AU 30 - 17930) **Fee:** $1,767.45 **Benefit:** 75% =$1,325.60 85% =$1,739.75
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (AU 30 - 17930) **Fee:** $1,767.45 **Benefit:** 75% =$1,325.60 85% =$1,739.75
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (AU 22 - 17922) **Fee:** $1,499.65 **Benefit:** 75% =$1,124.75 85% =$1,471.95
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (AU 22 - 17922) **Fee:** $1,499.65 **Benefit:** 75% =$1,124.75 85% =$1,471.95
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (AU 18 - 17918) **Fee:** $1,167.60 **Benefit:** 75% = $875.70 85% =$1,139.90
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Group applies (AU 21 - 17921) **Fee:** $910.50 **Benefit:** 75% = $682.90 85% = $882.80
	ENDARTERECTOMY AND ARTERIAL PATCH
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (AU 17 - 17917) **Fee:** $808.75 **Benefit:** 75% = $606.60 85% = $781.05
33503	INTERNAL CAROTID ARTERY, re-operation for recurrent stenosis with endarterectomy and closure by suture (AU 19 - 17919) **Fee:** $1,022.95 **Benefit:** 75% = $767.25 85% = $995.25
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (AU 18 - 17918) **Fee:** $905.15 **Benefit:** 75% = $678.90 85% = $877.45
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (AU 18 - 17918) **Fee:** $937.30 **Benefit:** 75% = $703.00 85% = $909.60
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (AU 19 - 17919) **Fee:** $1,012.25 **Benefit:** 75% = $759.20 85% = $984.55
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (AU 20 - 17920) **Fee:** $1,087.25 **Benefit:** 75% = $815.45 85% =$1,059.55

33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (AU 17 - 17917) **Fee:** $905.15 **Benefit:** 75% = $678.90 85% = $877.45
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (AU 17 - 17917) **Fee:** $980.10 **Benefit:** 75% = $735.10 85% = $952.40
33524	RENAL ARTERY, endarterectomy of (AU 19 - 17919) **Fee:** $1,156.85 **Benefit:** 75% = $867.65 85% =$1,129.15
33527	RENAL ARTERIES (both), endarterectomy of (AU 21 - 17921) **Fee:** $1,344.30 **Benefit:** 75% =$1,008.25 85% =$1,316.60
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (AU 19 - 17919) **Fee:** $1,156.85 **Benefit:** 75% = $867.65 85% =$1,129.15
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (AU 20 - 17920) **Fee:** $1,344.30 **Benefit:** 75% =$1,008.25 85% =$1,316.60
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another other item in this Group applies (AU 19 - 17919) **Fee:** $958.70 **Benefit:** 75% = $719.05 85% = $931.00
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (AU 12 - 17912) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $663.20
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (AU 17 - 17917) **Fee:** $985.50 **Benefit:** 75% = $739.15 85% = $957.80
33545	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 - 17913) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $194.95 **Benefit:** 75% = $146.25 85% = $167.25
33548	ARTERY OR VEIN, patch grafting to by vein or synthetic material in conjunction with another arterial or venous operation where patch is 3cm long or greater (AU 14 - 17914) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $396.35 **Benefit:** 75% = $297.30 85% = $368.65
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (AU 9 - 17909) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $194.95 **Benefit:** 75% = $146.25 85% = $167.25
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (AU 16 - 17916) **Fee:** $100.70 **Benefit:** 75% = $75.55 85% = $85.60
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (AU 15 - 17915) **Fee:** $840.85 **Benefit:** 75% = $630.65 85% = $813.15
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (AU 16 - 17916) **Fee:** $803.40 **Benefit:** 75% = $602.55 85% = $775.70
33806	EMBOLECTOMY OR THROMBECTOMY, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (AU 11 - 17911) **Fee:** $578.45 **Benefit:** 75% = $433.85 85% = $550.75
33809	INFERIOR VENA CAVA OR ILIAC VEIN, thrombectomy of (AU 12 - 17912) **Fee:** $712.35 **Benefit:** 75% = $534.30 85% = $684.65
33812	THROMBUS, removal of, from femoral or other similar large vein (AU 10 - 17910) **Fee:** $664.15 **Benefit:** 75% = $498.15 85% = $636.45

33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (AU 12 - 17912) **Fee:** $610.55 **Benefit:** 75% = $457.95 85% = $582.85
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (AU 13 - 17913) **Fee:** $712.35 **Benefit:** 75% = $534.30 85% = $684.65
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (AU 15 - 17915) **Fee:** $814.10 **Benefit:** 75% = $610.60 85% = $786.40
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (AU 13 - 17913) **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (AU 14 - 17914) **Fee:** $910.50 **Benefit:** 75% = $682.90 85% = $882.80
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (AU 16 - 17916) **Fee:** $1,044.40 **Benefit:** 75% = $783.30 85% =$1,016.70
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (AU 16 - 17916) **Fee:** $948.00 **Benefit:** 75% = $711.00 85% = $920.30
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (AU 17 - 17917) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (AU 18 - 17918) **Fee:** $1,322.90 **Benefit:** 75% = $992.20 85% =$1,295.20
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (AU 12 - 17912) **Fee:** $653.40 **Benefit:** 75% = $490.05 85% = $625.70
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (AU 14 - 17914) **Fee:** $455.25 **Benefit:** 75% = $341.45 85% = $427.55
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (AU 12 - 17912) **Fee:** $455.25 **Benefit:** 75% = $341.45 85% = $427.55
34100	**LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS** MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (AU 11 - 17911) **Fee:** $503.45 **Benefit:** 75% = $377.60 85% = $475.75
34103	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure (AU 13 - 17913) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure (AU 9 - 17909) **Fee:** $207.80 **Benefit:** 75% = $155.85 85% = $180.10
34109	TEMPORAL ARTERY, biopsy of (AU 7 - 17907) **Fee:** $241.00 **Benefit:** 75% = $180.75 85% = $213.30

34112	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and ligation (AU 14 - 17914) **Fee:** $610.55 **Benefit:** 75% = $457.95 85% = $582.85
34115	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and ligation (AU 17 - 17917) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $663.20
34118	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and ligation (AU 19 - 17919) **Fee:** $985.50 **Benefit:** 75% = $739.15 85% = $957.80
34121	ARTERIO-VENOUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (AU 18 - 17918) **Fee:** $787.30 **Benefit:** 75% = $590.50 85% = $759.60
34124	ARTERIO-VENOUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (AU 18 - 17918) **Fee:** $862.30 **Benefit:** 75% = $646.75 85% = $834.60
34127	ARTERIO-VENOUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (AU 22 - 17922) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
34130	SURGICALLY CREATED ARTERIO-VENOUS FISTULA OF AN EXTREMITY, closure of (AU 10 - 17910) **Fee:** $353.50 **Benefit:** 75% = $265.15 85% = $325.80
34133	SCALENOTOMY (AU 10 - 17910) **Fee:** $396.35 **Benefit:** 75% = $297.30 85% = $368.65
34136	FIRST RIB, resection of portion of (AU 13 - 17913) **Fee:** $637.35 **Benefit:** 75% = $478.05 85% = $609.65
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Group applies (AU 13 - 17913) **Fee:** $637.35 **Benefit:** 75% = $478.05 85% = $609.65
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (AU 19 - 17919) **Fee:** $787.30 **Benefit:** 75% = $590.50 85% = $759.60
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (AU 13 - 17913) **Fee:** $573.10 **Benefit:** 75% = $429.85 85% = $545.40
34148	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 - 17919) **Fee:** $1,022.95 **Benefit:** 75% = $767.25 85% = $995.25
34151	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 - 17919) **Fee:** $1,397.90 **Benefit:** 75% =$1,048.45 85% =$1,370.20
34154	RECURRENT CAROTID BODY TUMOUR, resection of, with or without repair or replacement of portion of common or internal carotid arteries (AU 19 - 17919) **Fee:** $1,665.70 **Benefit:** 75% =$1,249.30 85% =$1,638.00
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (AU 15 - 17915) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (AU 24 - 17924) **Fee:** $1,585.35 **Benefit:** 75% =$1,189.05 85% =$1,557.65
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (AU 26 - 17926) **Fee:** $2,035.25 **Benefit:** 75% =$1,526.45 85% =$2,007.55
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (AU 26 - 17926) **Fee:** $2,035.25 **Benefit:** 75% =$1,526.45 85% =$2,007.55

34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (AU 20 - 17920) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (AU 15 - 17915) **Fee:** $921.20 **Benefit:** 75% = $690.90 85% = $893.50
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (AU 15 - 17915) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
	OPERATIONS FOR VASCULAR ACCESS
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (AU 9 - 17909) **Fee:** $219.60 **Benefit:** 75% = $164.70 85% = $191.90
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (AU 14 - 17914) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (AU 5 - 17905) **Fee:** $149.95 **Benefit:** 75% = $112.50 85% = $127.50
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (AU 14 - 17914) **Fee:** $696.25 **Benefit:** 75% = $522.20 85% = $668.55
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (AU 14 - 17914) **Fee:** $765.90 **Benefit:** 75% = $574.45 85% = $738.20
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (AU 11 - 17911) **Fee:** $546.30 **Benefit:** 75% = $409.75 85% = $518.60
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (AU 14 - 17914) **Fee:** $915.85 **Benefit:** 75% = $686.90 85% = $888.15
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of for infusion chemotherapy, by open operation (excluding aftercare) (AU 11 - 17911) **Fee:** $374.90 **Benefit:** 75% = $281.20 85% = $347.20
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (AU 10 - 17910) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
34527	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 - 17911) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
34530	HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of (AU 10 - 17910) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
34533	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 - 17918) **Fee:** $883.70 **Benefit:** 75% = $662.80 85% = $856.00
	COMPLEX VENOUS OPERATIONS
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (AU 13 - 17913) **Fee:** $578.45 **Benefit:** 75% = $433.85 85% = $550.75
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (AU 24 - 17924) **Fee:** $1,274.70 **Benefit:** 75% = $956.05 85% =$1,247.00

34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (AU 14 - 17914) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $663.20
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (AU 14 - 17914) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $663.20
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (AU 13 - 17913) **Fee:** $835.50 **Benefit:** 75% = $626.65 85% = $807.80
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (AU 15 - 17915) *(See para T8.17 of explanatory notes to this Category)* **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $663.20
34818	VENOUS VALVE, plication or repair to restore valve competency (AU 25 - 17925) **Fee:** $760.55 **Benefit:** 75% = $570.45 85% = $732.85
34821	VEIN TRANSPLANT to restore valvular function (AU 15 - 17915) **Fee:** $1,033.70 **Benefit:** 75% = $775.30 85% =$1,006.00
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (AU 10 - 17910) **Fee:** $353.50 **Benefit:** 75% = $265.15 85% = $325.80
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (AU 11 - 17911) **Fee:** $428.45 **Benefit:** 75% = $321.35 85% = $400.75
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (AU 11 - 17911) **Fee:** $503.45 **Benefit:** 75% = $377.60 85% = $475.75
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (AU 12 - 17912) **Fee:** $653.40 **Benefit:** 75% = $490.05 85% = $625.70
	SYMPATHECTOMY
35000	LUMBAR SYMPATHECTOMY (AU 11 - 17911) **Fee:** $503.45 **Benefit:** 75% = $377.60 85% = $475.75
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (AU 16 - 17916) **Fee:** $653.40 **Benefit:** 75% = $490.05 85% = $625.70
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (AU 13 - 17913) **Fee:** $819.45 **Benefit:** 75% = $614.60 85% = $791.75
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (AU 11 - 17911) **Fee:** $637.35 **Benefit:** 75% = $478.05 85% = $609.65
	DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (AU 8 - 17908) **Fee:** $262.45 **Benefit:** 75% = $196.85 85% = $234.75
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (AU 9 - 17909) **Fee:** $167.10 **Benefit:** 75% = $125.35 85% = $142.05

	MISCELLANEOUS VASCULAR PROCEDURES
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (AU 8 - 17908) **Fee:** $122.10 **Benefit:** 75% = $91.60 85% = $103.80
‡ 35300	**ENDOVASCULAR INTERVENTIONAL PROCEDURES** TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 10 - 17910) **Fee:** $367.15 **Benefit:** 75% = $275.40 85% = $339.45
‡ 35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 12 - 17912) **Fee:** $470.60 **Benefit:** 75% = $352.95 85% = $442.90
35304	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 10 - 17910) **Fee:** $367.15 **Benefit:** 75% = $275.40 85% = $339.45
35305	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (AU 12 - 17912) **Fee:** $470.60 **Benefit:** 75% = $352.95 85% = $442.90
‡ 35306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 11 - 17911) **Fee:** $434.40 **Benefit:** 75% = $325.80 85% = $406.70
‡ 35309	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 13 - 17913) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $515.30
35310	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (AU 13 - 17913) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $515.30
‡ 35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 13 - 17913) **Fee:** $615.40 **Benefit:** 75% = $461.55 85% = $587.70
‡ 35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 13 - 17913) **Fee:** $615.40 **Benefit:** 75% = $461.55 85% = $587.70
35318	PERIPHERAL ARTERIAL or VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which item 13903 applies) (AU 6 - 17906) **Fee:** $253.40 **Benefit:** 75% = $190.05 85% = $225.70
35321	PERIPHERAL ARTERIAL CATHETERISATION to administer agents to occlude arteries, vein or arterio-venous fistulae or to arrest haemorrhage, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 12 - 17912) **Fee:** $579.20 **Benefit:** 75% = $434.40 85% = $551.50
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (AU 8 - 17908) **Fee:** $217.20 **Benefit:** 75% = $162.90 85% = $189.50
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (AU 6 - 17906) **Fee:** $108.60 **Benefit:** 75% = $81.45 85% = $92.35

35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (AU 11 - 17911) **Fee:** $367.15 **Benefit:** 75% = $275.40 85% = $339.45
	SUBGROUP 4 - GYNAECOLOGICAL
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $57.90 **Benefit:** 75% = $43.45 85% = $49.25
35503	INTRA-UTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $38.15 **Benefit:** 75% = $28.65 85% = $32.45
35506	INTRA-UTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $38.15 **Benefit:** 75% = $28.65 85% = $32.45
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (AU 6 - 17906) **Fee:** $124.30 **Benefit:** 75% = $93.25 85% = $105.70
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (AU 11 - 17911) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
35509	HYMENECTOMY (AU 5 - 17905) **Fee:** $63.85 **Benefit:** 75% = $47.90 85% = $54.30
35512 G 35513 S	BARTHOLIN'S CYST, excision of (AU 7 - 17907) **Fee:** $127.70 **Benefit:** 75% = $95.80 85% = $108.55 **Fee:** $157.95 **Benefit:** 75% = $118.50 85% = $134.30
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (AU 6 - 17906) **Fee:** $82.95 **Benefit:** 75% = $62.25 85% = $70.55 **Fee:** $104.00 **Benefit:** 75% = $78.00 85% = $88.40
35520	BARTHOLIN'S ABSCESS, incision of (AU 5 - 17905) **Fee:** $41.45 **Benefit:** 75% = $31.10 85% = $35.25
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (AU 4 - 17904) **Fee:** $41.45 **Benefit:** 75% = $31.10 85% = $35.25
35526 G 35527 S	URETHRAL CARUNCLE, excision of (AU 6 - 17906) **Fee:** $82.95 **Benefit:** 75% = $62.25 85% = $70.55 **Fee:** $104.00 **Benefit:** 75% = $78.00 85% = $88.40
35530	CLITORIS, amputation of, where medically indicated (AU 7 - 17907) **Fee:** $192.20 **Benefit:** 75% = $144.15 85% = $164.50
35533	VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (AU 9 - 17909) **Fee:** $249.20 **Benefit:** 75% = $186.90 85% = $221.50
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (AU 9 - 17909) **Fee:** $248.20 **Benefit:** 75% = $186.15 85% = $220.50
35539	COLPOSCOPICALLY DIRECTED CO2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies - 1 anatomical site (AU 5 - 17905) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75

35542	COLPOSCOPICALLY DIRECTED CO2 LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies - 2 or more anatomical sites (AU 6 - 17906) **Fee:** $227.55 **Benefit:** 75% = $170.70 85% = $199.85
35545	COLPOSCOPICALLY DIRECTED CO2 LASER THERAPY for condylomata, unsuccessfully treated by other methods (AU 6 - 17906) **Fee:** $130.80 **Benefit:** 75% = $98.10 85% = $111.20
35548	VULVECTOMY, radical, for malignancy (AU 17 - 17917) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
35551	PELVIC LYMPH GLANDS, excision of (radical) (AU 15 - 17915) **Fee:** $487.05 **Benefit:** 75% = $365.30 85% = $459.35
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (AU 4 - 17904) **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (AU 8 - 17908) **Fee:** $152.70 **Benefit:** 75% = $114.55 85% = $129.80
35560	VAGINA, partial or complete removal of (AU 13 - 17913) **Fee:** $487.05 **Benefit:** 75% = $365.30 85% = $459.35
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (AU 25 - 17925) **Fee:** $982.55 **Benefit:** 75% = $736.95 85% = $954.85
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (AU 25 - 17925) **Fee:** $806.70 **Benefit:** 75% = $605.05 85% = $779.00
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon **Fee:** $372.35 **Benefit:** 75% = $279.30 85% = $344.65
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (AU 18 - 17918) **Fee:** $486.10 **Benefit:** 75% = $364.60 85% = $458.40
35566	VAGINAL SEPTUM, excision of, for correction of double vagina (AU 12 - 17912) **Fee:** $283.00 **Benefit:** 75% = $212.25 85% = $255.30
35567	VAGINAL REPAIR (involving repair of enterocele) with transvaginal sacrospinus ligament colposuspension (AU 10 - 17910) **Fee:** $356.80 **Benefit:** 75% = $267.60 85% = $329.10
35569	PLASTIC REPAIR TO ENLARGE VAGINAL ORIFICE (AU 9 - 17909) **Fee:** $114.50 **Benefit:** 75% = $85.90 85% = $97.35
35572	COLPOTOMY - not being a service to which another item in this Group applies (AU 6 - 17906) **Fee:** $88.20 **Benefit:** 75% = $66.15 85% = $75.00
35575 G 35576 S	ANTERIOR VAGINAL REPAIR OR POSTERIOR VAGINAL REPAIR (involving repair of rectocele or enterocele or both) not being a service to which item 35579, 35580, 35583 or 35584 applies (AU 10 - 17910) **Fee:** $247.45 **Benefit:** 75% = $185.60 85% = $219.75 **Fee:** $302.75 **Benefit:** 75% = $227.10 85% = $275.05
35579 G 35580 S	ANTERIOR VAGINAL REPAIR AND POSTERIOR VAGINAL REPAIR (involving repair of rectocele or enterocele or both) not being a service to which item 35583 or 35584 applies (AU 10 - 17910) **Fee:** $302.75 **Benefit:** 75% = $227.10 85% = $275.05 **Fee:** $381.75 **Benefit:** 75% = $286.35 85% = $354.05
35583 G 35584 S	DONALD-FOTHERGILL OR MANCHESTER OPERATION FOR GENITAL PROLAPSE (AU 10 - 17910) **Fee:** $362.00 **Benefit:** 75% = $271.50 85% = $334.30 **Fee:** $480.45 **Benefit:** 75% = $360.35 85% = $452.75
35587	URETHROCELE, operation for (AU 9 - 17909) **Fee:** $125.05 **Benefit:** 75% = $93.80 85% = $106.30

35590	Operation involving ABDOMINAL APPROACH for repair of ENTEROCELE OR SUSPENSION OF VAGINAL VAULT OR ENTEROCELE AND SUSPENSION OF VAGINAL VAULT (AU 9 - 17909) **Fee:** $381.75 **Benefit:** 75% = $286.35 85% = $354.05
35593	VAGINAL REPAIR OF ENTEROCELE with or without repair of rectocele, not being a service associated with a service to which item 35575, 35576, 35579, 35580, 35583, 35584, 35590, 35656, 35657 or 35673 applies, and where on a previous occasion there has been performed surgery reflected by a procedure to which item 35575, 35576, 35579, 35580, 35583, 35584, 35590, 35656, 35657 or 35673 applies (AU 8 - 17908) **Fee:** $379.70 **Benefit:** 75% = $284.80 85% = $352.00
35596	FISTULA BETWEEN GENITAL AND URINARY OR ALIMENTARY TRACTS, repair of, not being a service to which item 37029, 37333 or 37336 applies (AU 13 - 17913) **Fee:** $487.05 **Benefit:** 75% = $365.30 85% = $459.35
35599	STRESS INCONTINENCE, sling operation for (AU 12 - 17912) **Fee:** $480.45 **Benefit:** 75% = $360.35 85% = $452.75
35602	STRESS INCONTINENCE, combined synchronous ABDOMINO-VAGINAL operation for; abdominal procedure (including after-care) (AU 12 - 17912) **Fee:** $480.45 **Benefit:** 75% = $360.35 85% = $452.75
35605	STRESS INCONTINENCE, combined synchronous ABDOMINO-VAGINAL operation for; vaginal procedure (including after-care) **Fee:** $260.65 **Benefit:** 75% = $195.50 85% = $232.95
35608	CERVIX, cauterisation (other than by chemical means), ionisation, diathermy or biopsy of, with or without dilatation of cervix (AU 5 - 17905) **Fee:** $45.40 **Benefit:** 75% = $34.05 85% = $38.60
35611	CERVIX, removal of polyp or polypi, with or without dilatation of cervix, not being a service associated with a service to which item 35608 applies (AU 5 - 17905) **Fee:** $45.15 **Benefit:** 75% = $33.90 85% = $38.40
35614	EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmann-type colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (AU 5 - 17905) *(See para T8.18 of explanatory notes to this Category)* **Fee:** $45.40 **Benefit:** 75% = $34.05 85% = $38.60
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies **Fee:** $38.25 **Benefit:** 75% = $28.70 85% = $32.55
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35583 or 35584 applies (AU 7 - 17907) **Fee:** $123.75 **Benefit:** 75% = $92.85 85% = $105.20 **Fee:** $152.70 **Benefit:** 75% = $114.55 85% = $129.80
35621	CERVIX, dilatation of, under general anaesthesia, not being a service to which item 35639, 35640 or 35643 applies (AU 5 - 17905) *(See para T8.19 of explanatory notes to this Category)* **Fee:** $57.90 **Benefit:** 75% = $43.45 85% = $49.25
35624	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (AU 5 - 17905) **Fee:** $37.95 **Benefit:** 75% = $28.50 85% = $32.30
35625	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) **Fee:** $429.20 **Benefit:** 75% = $321.90 85% = $401.50
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies and including procedures to which item 35639, 35640 or 35643 applies, where performed *(See para T8.20 of explanatory notes to this Category)* **Fee:** $58.95 **Benefit:** 75% = $44.25 85% = $50.15

35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35630 applies, and including procedures to which item 35639, 35640 or 35643 applies, where performed (AU 7 - 17907) **Fee:** $76.35 **Benefit:** 75% = $57.30 85% = $64.90
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35627 applies, and including procedures to which item 35639, 35640 or 35643 applies, where performed (AU 7 - 17907) **Fee:** $130.30 **Benefit:** 75% = $97.75 85% = $110.80
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation or removal of IUD which cannot be removed by other means, 1 or more of (AU 8 - 17908) **Fee:** $154.25 **Benefit:** 75% = $115.70 85% = $131.15
35636	HYSTEROSCOPY AND LAPAROSCOPY under general anaesthesia involving either myomectomy or resection of uterine septum, or both (AU 10 - 17910) **Fee:** $308.50 **Benefit:** 75% = $231.40 85% = $280.80
‡ 35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (AU 7 - 17907) **Fee:** $289.60 **Benefit:** 75% = $217.20 85% = $261.90
35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, division of adhesions requiring more than 1 hours operating time or division of utero-sacral ligaments for significant dysmenorrhoea (AU 12 - 17912) **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility (AU 5 - 17905) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $96.10 **Benefit:** 75% = $72.10 85% = $81.70 **Fee:** $130.30 **Benefit:** 75% = $97.75 85% = $110.80
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies (AU 5 - 17905) **Fee:** $155.30 **Benefit:** 75% = $116.50 85% = $132.05
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639, 35640 or 35647 applies (AU 8 - 17908) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $144.95 **Benefit:** 75% = $108.75 85% = $123.25
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (AU 8 - 17908) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $227.05 **Benefit:** 75% = $170.30 85% = $199.35
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital or approved day-hospital facility (AU 8 - 17908) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $144.80 **Benefit:** 75% = $108.60 85% = $123.10
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (AU 8 - 17908) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $144.95 **Benefit:** 75% = $108.75 85% = $123.25

35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (AU 8 - 17908) *(See para T8.22 of explanatory notes to this Category)* **Fee:** $227.05 **Benefit:** 75% = $170.30 85% = $199.35
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (AU 10 - 17910) **Fee:** $381.75 **Benefit:** 75% = $286.35 85% = $354.05
35653	HYSTERECTOMY, ABDOMINAL, SUB-TOTAL or TOTAL, with or without removal of uterine adnexae (AU 11 - 17911) **Fee:** $480.45 **Benefit:** 75% = $360.35 85% = $452.75
35657	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies (AU 11 - 17911) **Fee:** $480.55 **Benefit:** 75% = $360.45 85% = $452.85
35661	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometrioses, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (AU 12 - 17912) **Fee:** $620.55 **Benefit:** 75% = $465.45 85% = $592.85
35664	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (AU 17 - 17917) **Fee:** $1,034.25 **Benefit:** 75% = $775.70 85% =$1,006.55
35667	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (AU 17 - 17917) **Fee:** $879.10 **Benefit:** 75% = $659.35 85% = $851.40
35670	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (AU 19 - 17919) **Fee:** $723.80 **Benefit:** 75% = $542.85 85% = $696.10
35673	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (AU 12 - 17912) **Fee:** $539.70 **Benefit:** 75% = $404.80 85% = $512.00
35676 G 35677 S	ECTOPIC PREGNANCY, removal of (AU 9 - 17909) **Fee:** $302.75 **Benefit:** 75% = $227.10 85% = $275.05 **Fee:** $381.75 **Benefit:** 75% = $286.35 85% = $354.05
35678	ECTOPIC PREGNANCY, laparoscopic removal of (AU 10 - 17910) **Fee:** $460.25 **Benefit:** 75% = $345.20 85% = $432.55
35680	BICORNUATE UTERUS, plastic reconstruction for (AU 14 - 17914) **Fee:** $414.65 **Benefit:** 75% = $311.00 85% = $386.95
35683 G 35684 S	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (AU 8 - 17908) **Fee:** $250.10 **Benefit:** 75% = $187.60 85% = $222.40 **Fee:** $335.65 **Benefit:** 75% = $251.75 85% = $307.95
35687 G 35688 S	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method (AU 8 - 17908) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $203.95 **Fee:** $283.00 **Benefit:** 75% = $212.25 85% = $255.30
35691	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section (AU 5 - 17905) **Fee:** $113.00 **Benefit:** 75% = $84.75 85% = $96.05

35694	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (AU 11 - 17911) **Fee:** $454.15 **Benefit:** 75% = $340.65 85% = $426.45
35697	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (AU 16 - 17916) **Fee:** $673.90 **Benefit:** 75% = $505.45 85% = $646.20
35700	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope (AU 18 - 17918) **Fee:** $519.95 **Benefit:** 75% = $390.00 85% = $492.25
35703	HYDROTUBATION OF FALLOPIAN TUBES as a non-repetitive procedure not being a service associated with a service to which another item in this Group applies (AU 7 - 17907) **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85
35706	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (AU 7 - 17907) **Fee:** $48.05 **Benefit:** 75% = $36.05 85% = $40.85
35709	FALLOPIAN TUBES, hydrotubation of, as a repetitive post-operative procedure (AU 7 - 17907) **Fee:** $30.95 **Benefit:** 75% = $23.25 85% = $26.35
35712 G 35713 S	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARA-OVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (AU 9 - 17909) **Fee:** $258.00 **Benefit:** 75% = $193.50 85% = $230.30 **Fee:** $322.50 **Benefit:** 75% = $241.90 85% = $294.80
35716 G 35717 S	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGO-OOPHORECTOMY, removal of OVARIAN, PARA-OVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (AU 10 - 17910) **Fee:** $309.35 **Benefit:** 75% = $232.05 85% = $281.65 **Fee:** $388.30 **Benefit:** 75% = $291.25 85% = $360.60
35720	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (AU 16 - 17916) *(See para T8.23 of explanatory notes to this Category)* **Fee:** $480.45 **Benefit:** 75% = $360.35 85% = $452.75
35723	RETRO-PERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (AU 19 - 17919) **Fee:** $344.10 **Benefit:** 75% = $258.10 85% = $316.40
35726	INFRA-COLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (AU 16 - 17916) **Fee:** $344.10 **Benefit:** 75% = $258.10 85% = $316.40
35729	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (AU 18 - 17918) **Fee:** $155.15 **Benefit:** 75% = $116.40 85% = $131.90
	SUBGROUP 5 - UROLOGICAL
	GENERAL
36500	ADRENAL GLAND, excision of - partial or total (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (AU 24 - 17924) **Fee:** $990.80 **Benefit:** 75% = $743.10 85% = $963.10
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together - vascular anastomosis including after-care (AU 24 - 17924) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85

36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together - ureterovesical anastomosis including after-care **Fee:** $557.70 **Benefit:** 75% = $418.30 85% = $530.00
36515 G 36516 S	NEPHRECTOMY, complete (AU 11 - 17911) **Fee:** $545.85 **Benefit:** 75% = $409.40 85% = $518.15 **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (AU 13 - 17913) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
36522	NEPHRECTOMY, partial (AU 13 - 17913) **Fee:** $789.10 **Benefit:** 75% = $591.85 85% = $761.40
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (AU 15 - 17915) **Fee:** $1,121.35 **Benefit:** 75% = $841.05 85% =$1,093.65
36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy (AU 17 - 17917) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
36531	NEPHRO-URETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (AU 17 - 17917) **Fee:** $824.70 **Benefit:** 75% = $618.55 85% = $797.00
36534	KIDNEY, FUSED, renal symphysiotomy for (AU 14 - 17914) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Group applies (AU 10 - 17910) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
36540	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (AU 12 - 17912) **Fee:** $789.10 **Benefit:** 75% = $591.85 85% = $761.40
36543	NEPHROLITHOTOMY OR PYELOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (AU 12 - 17912) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and post-treatment care for 3 days, including pre-treatment consultation, unilateral (AU 12 - 17912) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
36549	URETEROLITHOTOMY (AU 11 - 17911) **Fee:** $593.30 **Benefit:** 75% = $445.00 85% = $565.60
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (AU 11 - 17911) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
36555	NEPHROPEXY, as an independent procedure (AU 9 - 17909) **Fee:** $361.90 **Benefit:** 75% = $271.45 85% = $334.20
36558	RENAL CYST OR CYSTS, excision or unroofing of (AU 11 - 17911) **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05
36561	RENAL BIOPSY (closed) (AU 6 - 17906) **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45
36564	PYELOPLASTY, by open exposure (AU 14 - 17914) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36567	PYELOPLASTY in congenitally abnormal kidney or solitary kidney, by open exposure (AU 14 - 17914) **Fee:** $723.80 **Benefit:** 75% = $542.85 85% = $696.10

36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (AU 15 - 17915) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
36573	DIVIDED URETER, repair of (AU 13 - 17913) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (AU 13 - 17913) **Fee:** $824.70 **Benefit:** 75% = $618.55 85% = $797.00
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (AU 12 - 17912) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
36582	URETER, replacement of, by bowel (AU 12 - 17912) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
36585	URETER, transplantation of, into skin (AU 10 - 17910) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
36588	URETER, reimplantation into bladder (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (AU 12 - 17912) **Fee:** $789.10 **Benefit:** 75% = $591.85 85% = $761.40
36594	URETER, transplantation of, into intestine (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36597	URETER, transplantation of, into another ureter (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (AU 14 - 17914) **Fee:** $789.10 **Benefit:** 75% = $591.85 85% = $761.40
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (AU 16 - 17916) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of non-return valves and implantation of ureters (1 or both) into reservoir (AU 27 - 17927) **Fee:** $1,649.35 **Benefit:** 75% =$1,237.05 85% =$1,621.65
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (AU 13 - 17913) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
36612	URETER, exploration of, with or without drainage of, as an independent procedure (AU 11 - 17911) **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05
36615	URETEROLYSIS, with or without repositioning of ureter, for retroperitoneal fibrosis, ovarian vein syndrome or similar condition (AU 11 - 17911) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
36618	REDUCTION URETEROPLASTY (AU 14 - 17914) **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (AU 9 - 17909) **Fee:** $330.75 **Benefit:** 75% = $248.10 85% = $303.05
36624	NEPHROSTOMY, percutaneous, including associated imaging (AU 9 - 17909) **Fee:** $397.50 **Benefit:** 75% = $298.15 85% = $369.80
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (AU 11 - 17911) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75

36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (AU 10 - 17910) **Fee:** $243.25 **Benefit:** 75% = $182.45 85% = $215.55
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (AU 11 - 17911) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627, 36639, 36642, 36645 or 36648 applies (AU 13 - 17913) **Fee:** $284.80 **Benefit:** 75% = $213.60 85% = $257.10
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (AU 13 - 17913) **Fee:** $593.30 **Benefit:** 75% = $445.00 85% = $565.60
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (AU 12 - 17912) **Fee:** $296.65 **Benefit:** 75% = $222.50 85% = $268.95
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cms in any dimension, or for 3 or more stones (AU 17 - 17917) **Fee:** $759.40 **Benefit:** 75% = $569.55 85% = $731.70
36648	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36645 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (AU 16 - 17916) **Fee:** $676.35 **Benefit:** 75% = $507.30 85% = $648.65
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (AU 7 - 17907) **Fee:** $190.65 **Benefit:** 75% = $143.00 85% = $162.95
	OPERATIONS ON THE BLADDER (CLOSED)
36800	BLADDER, catheterisation of, where no other procedure is performed (AU 4 - 17904) **Fee:** $19.70 **Benefit:** 75% = $14.80 85% = $16.75
36803	URETEROSCOPY, with or without any 1 or more of; cystoscopy, ureteric meatotomy, ureteric dilatation and pyeloscopy, not being a service associated with a service to which item 36806, 36809, 36812, 36824, 36848 or 36857 applies (AU 7 - 17907) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
36806	URETEROSCOPY, BEING A SERVICE TO WHICH ITEM 36803 APPLIES, PLUS 1 or more of extraction of stone, biopsy or diathermy (AU 9 - 17909) **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05
36809	URETEROSCOPY, BEING A SERVICE TO WHICH ITEM 36803 APPLIES, PLUS destruction of stone with ultrasound, electrohydraulic shock waves, or laser, with extraction of fragments (AU 11 - 17911) **Fee:** $593.30 **Benefit:** 75% = $445.00 85% = $565.60
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (AU 5 - 17905) **Fee:** $118.65 **Benefit:** 75% = $89.00 85% = $100.90
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or uretheral warts, not being a service associated with a service to which item 30189 applies (AU 6 - 17906) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $169.50 **Benefit:** 75% = $127.15 85% = $144.10
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (AU 6 - 17906) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25

36821	CYSTOSCOPY with 1 or more of; ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (AU 6 - 17906) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $202.50
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (AU 5 - 17905) **Fee:** $151.90 **Benefit:** 75% = $113.95 85% = $129.15
36827	CYSTOSCOPY, with controlled hydro-dilatation of the bladder (AU 5 - 17905) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
36830	CYSTOSCOPY, with ureteric meatotomy (AU 5 - 17905) **Fee:** $144.75 **Benefit:** 75% = $108.60 85% = $123.05
36833	CYSTOSCOPY WITH REMOVAL OF FOREIGN BODY (AU 6 - 17906) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36839, 36845, 36848, 36854, 37203, 37206 or 37215 applies (AU 6 - 17906) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
36839	CYSTOSCOPY, with resection or diathermy of bladder tumour or other lesion of the bladder or prostate, not being a service associated with a service to which item 36845 applies (AU 6 - 17906) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $202.50
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812, items 36827 to 36863, or items 37203 and 37206 apply (AU 8 - 17908) **Fee:** $231.65 **Benefit:** 75% = $173.75 85% = $203.95
36845	CYSTOSCOPY, with diathermy or resection of multiple bladder tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cms in diameter (AU 6 - 17906) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
36848	CYSTOSCOPY, with resection of ureterocele (AU 5 - 17905) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
36851	CYSTOSCOPY, with injection into bladder wall (AU 5 - 17905) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (AU 7 - 17907) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (AU 6 - 17906) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $233.35
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (AU 5 - 17905) **Fee:** $118.65 **Benefit:** 75% = $89.00 85% = $100.90
36863	LITHOLAPAXY, with or without cystoscopy (AU 7 - 17907) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
	OPERATIONS ON THE BLADDER (OPEN)
37000	BLADDER, partial excision of (AU 13 - 17913) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37003 G 37004 S	BLADDER, repair of rupture (AU 13 - 17913) **Fee:** $379.70 **Benefit:** 75% = $284.80 85% = $352.00 **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05

37007 G 37008 S	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (AU 8 - 17908) **Fee:** $237.30 **Benefit:** 75% = $178.00 85% = $209.60 **Fee:** $296.65 **Benefit:** 75% = $222.50 85% = $268.95
37011	SUPRAPUBIC STAB CYSTOTOMY (AU 6 - 17906) **Fee:** $66.45 **Benefit:** 75% = $49.85 85% = $56.50
37014	BLADDER, total excision of (AU 29 - 17929) **Fee:** $759.40 **Benefit:** 75% = $569.55 85% = $731.70
37017	BLADDER TUMOURS, suprapubic diathermy of (AU 10 - 17910) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
37020	BLADDER DIVERTICULUM, excision or obliteration of (AU 10 - 17910) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37023	VESICAL FISTULA, cutaneous, operation for (AU 12 - 17912) **Fee:** $296.65 **Benefit:** 75% = $222.50 85% = $268.95
37026	CUTANEOUS VESICOSTOMY, establishment of (AU 9 - 17909) **Fee:** $296.65 **Benefit:** 75% = $222.50 85% = $268.95
37029	VESICO-VAGINAL FISTULA, closure of, by abdominal approach (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37032	VESICO-VAGINAL FISTULA, closure of, synchronous combined approach, abdominal component, including aftercare (AU 12 - 17912) **Fee:** $593.30 **Benefit:** 75% = $445.00 85% = $565.60
37035	VESICO-VAGINAL FISTULA, closure of, synchronous combined approach, vaginal component, including aftercare **Fee:** $427.15 **Benefit:** 75% = $320.40 85% = $399.45
37038	VESICO-INTESTINAL FISTULA, closure of, excluding bowel resection (AU 11 - 17911) **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05
37041	BLADDER ASPIRATION by needle **Fee:** $33.20 **Benefit:** 75% = $24.90 85% = $28.25
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, not being a service to which item 35599 applies (AU 9 - 17909) **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05
37047	BLADDER ENLARGEMENT using intestine (AU 23 - 17923) **Fee:** $1,186.60 **Benefit:** 75% = $889.95 85% =$1,158.90
37050	BLADDER EXTROPHY CLOSURE, not involving sphincter reconstruction (AU 14 - 17914) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (AU 16 - 17916) **Fee:** $610.25 **Benefit:** 75% = $457.70 85% = $582.55
	OPERATIONS ON THE PROSTATE
37200	PROSTATECTOMY, open (AU 13 - 17913) **Fee:** $723.80 **Benefit:** 75% = $542.85 85% = $696.10
37203	PROSTATECTOMY (endoscopic), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies (AU 10 - 17910) **Fee:** $824.70 **Benefit:** 75% = $618.55 85% = $797.00

37206	PROSTATECTOMY (endoscopic), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37303, 37321 or 37324 applies, continuation of, within 10 days of initial procedure which had to be discontinued for medical reasons (AU 9 - 17909) **Fee:** $397.50 **Benefit:** 75% = $298.15 85% = $369.80
37209	PROSTATE, total excision of (AU 13 - 17913) **Fee:** $919.60 **Benefit:** 75% = $689.70 85% = $891.90
37212	PROSTATE, open perineal biopsy or open drainage of abscess (AU 6 - 17906) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (AU 6 - 17906) **Fee:** $296.65 **Benefit:** 75% = $222.50 85% = $268.95
37218	PROSTATE, needle biopsy of, or injection into (AU 5 - 17905) **Fee:** $98.50 **Benefit:** 75% = $73.90. 85% = $83.75
37221	PROSTATIC ABSCESS, endoscopic drainage of (AU 7 - 17907) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
	OPERATIONS ON URETHRA, PENIS OR SCROTUM
37300	URETHRAL SOUNDS, passage of, as an independent procedure (AU 5 - 17905) **Fee:** $33.20 **Benefit:** 75% = $24.90 85% = $28.25
37303	URETHRAL STRICTURE, dilatation of (AU 5 - 17905) **Fee:** $52.80 **Benefit:** 75% = $39.60 85% = $44.90
37306	URETHRA, repair of rupture of distal section (AU 9 - 17909) **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05
37309	URETHRA, repair of rupture of prostatic or membranous segment (AU 10 - 17910) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37312	URETHRAL FISTULA, closure of (AU 8 - 17908) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37315	URETHROSCOPY, as an independent procedure (AU 5 - 17905) **Fee:** $98.50 **Benefit:** 75% = $73.90 85% = $83.75
37318	URETHROSCOPY with any 1 or more of; biopsy, diathermy or removal of foreign body or stone (AU 7 - 17907) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37321	URETHRAL MEATOTOMY, EXTERNAL (AU 4 - 17904) **Fee:** $66.45 **Benefit:** 75% = $49.85 85% = $56.50
37324	URETHROTOMY OR URETHROSTOMY, internal or external (AU 5 - 17905) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
37327	URETHROTOMY, optical, for urethral stricture (AU 5 - 17905) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $202.50
37330	URETHRECTOMY, partial or complete, for removal of tumour (AU 9 - 17909) **Fee:** $462.75 **Benefit:** 75% = $347.10 85% = $435.05
37333	URETHRO-VAGINAL FISTULA, closure of (AU 9 - 17909) **Fee:** $397.50 **Benefit:** 75% = $298.15 85% = $369.80
37336	URETHRO-RECTAL FISTULA, closure of (AU 10 - 17910) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37339	PERI-URETHRAL INJECTION of Teflon, including urethroscopy and cystoscopy (AU 5 - 17905) **Fee:** $170.85 **Benefit:** 75% = $128.15 85% = $145.25

37342	URETHROPLASTY - single stage operation (AU 10 - 17910) **Fee:** $593.30 **Benefit:** 75% = $445.00 85% = $565.60
37345	URETHROPLASTY - 2 stage operation - first stage (AU 9 - 17909) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
37348	URETHROPLASTY - 2 stage operation - second stage (AU 9 - 17909) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
37351	URETHROPLASTY, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37354	HYPOSPADIAS, meatotomy and hemi-circumcision (AU 7 - 17907) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $202.50
37357	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (AU 8 - 17908) **Fee:** $296.65 **Benefit:** 75% = $222.50 85% = $268.95
37360	HYPOSPADIAS OR EPISPADIAS, with or without chordee, correction of, as a staged procedure, first stage (AU 10 - 17910) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
37363	HYPOSPADIAS OR EPISPADIAS, with or without chordee, correction of, as a staged procedure, second stage (AU 11 - 17911) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
37366	HYPOSPADIAS OR EPISPADIAS, with or without chordee, correction of, as 1 stage procedure, not being a service to which item 37357 applies (AU 13 - 17913) **Fee:** $593.30 **Benefit:** 75% = $445.00 85% = $565.60
37369	URETHRA, excision of prolapse of (AU 7 - 17907) **Fee:** $132.90 **Benefit:** 75% = $99.70 85% = $113.00
37372	URETHRAL DIVERTICULUM, excision of (AU 8 - 17908) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (AU 16 - 17916) **Fee:** $824.70 **Benefit:** 75% = $618.55 85% = $797.00
37378	URETHRA, operation for correction of male urinary incontinence, not being a service to which item 37381 or 37390 applies (AU 9 - 17909) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (AU 10 - 17910) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (AU 16 - 17916) **Fee:** $824.70 **Benefit:** 75% = $618.55 85% = $797.00
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (AU 8 - 17908) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $202.50
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37393	PRIAPISM, decompression by glanular stab cavernoso-spongiosum shunt or penile aspiration with or without lavage (AU 7 - 17907) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (AU 10 - 17910) **Fee:** $528.05 **Benefit:** 75% = $396.05 85% = $500.35
37399	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (AU 7 - 17907) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $233.35

37402	PENIS, partial amputation of (AU 8 - 17908) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
37405	PENIS, complete or radical amputation of (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (AU 8 - 17908) **Fee:** $332.25 **Benefit:** 75% = $249.20 85% = $304.55
37411	PENIS, repair of avulsion (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37414	PENIS, injection of, for investigation or treatment of impotence, priapism or Peyronie's plaque **Fee:** $33.20 **Benefit:** 75% = $24.90 85% = $28.25
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (AU 8 - 17908) **Fee:** $397.50 **Benefit:** 75% = $298.15 85% = $369.80
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Bucks fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (AU 7 - 17907) **Fee:** $261.05 **Benefit:** 75% = $195.80 85% = $233.35
37423	PENIS, lengthening by translocation of corpora (AU 14 - 17914) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (AU 8 - 17908) **Fee:** $694.15 **Benefit:** 75% = $520.65 85% = $666.45
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (AU 11 - 17911) **Fee:** $230.20 **Benefit:** 75% = $172.65 85% = $202.50
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (AU 11 - 17911) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85
37435	PENIS, frenuloplasty as an independent procedure (AU 5 - 17905) **Fee:** $66.45 **Benefit:** 75% = $49.85 85% = $56.50
37438	SCROTUM, partial excision of (AU 7 - 17907) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37441	PENIS ERECTION TEST FOR HYPOSPADIAS AND CHORDEE when performed under general anaesthesia, as an independent procedure (AU 5 - 17905) **Fee:** $65.55 **Benefit:** 75% = $49.20 85% = $55.75
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (AU 12 - 17912) **Fee:** $711.95 **Benefit:** 75% = $534.00 85% = $684.25
	OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES
37600 G 37601 S	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (AU 6 - 17906) **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20 **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral (AU 5 - 17905) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (AU 12 - 17912) **Fee:** $658.55 **Benefit:** 75% = $493.95 85% = $630.85

37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (AU 24 - 17924) **Fee:** $990.80 **Benefit:** 75% = $743.10 85% = $963.10
37613	EPIDIDYMECTOMY (AU 8 - 17908) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37616	VASO-VASOSTOMY or VASO-EPIDIDYMOSTOMY, unilateral, using operating microscope (AU 14 - 17914) **Fee:** $492.45 **Benefit:** 75% = $369.35 85% = $464.75
37619	VASO-VASOSTOMY or VASO-EPIDIDYMOSTOMY, unilateral (AU 9 - 17909) **Fee:** $196.95 **Benefit:** 75% = $147.75 85% = $169.25
37622 G 37623 S	VASOTOMY OR VASECTOMY, unilateral or bilateral (AU 5 - 17905) **Fee:** $137.70 **Benefit:** 75% = $103.30 85% = $117.05 **Fee:** $163.75 **Benefit:** 75% = $122.85 85% = $139.20
	SUBGROUP 6 - CARDIO-THORACIC
	MISCELLANEOUS CARDIAC PROCEDURES
38200	RIGHT HEART CATHERISATION, including fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection and exercise stress test (AU 12 - 17912) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture - including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (AU 12 - 17912) **Fee:** $378.60 **Benefit:** 75% = $283.95 85% = $350.90
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure - including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (AU 14 - 17914) **Fee:** $457.70 **Benefit:** 75% = $343.30 85% = $430.00
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY - up to and including 3 catheter investigation of any 1 or more of - syncope, atrio-ventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 applies (AU 19 - 17919) **Fee:** $587.65 **Benefit:** 75% = $440.75 85% = $559.95
38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY - 4 or more catheter supraventricular tachycardia investigation; or complex ventricular tachycardia investigation involving multiple ventricular tachycardia inductions, or multiple catheter mapping, or acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or catheter ablation; or intra-operative mapping; or electrophysiological services during defibrillator implantation or testing - not being a service associated with a service to which item 38209 applies (AU 27 - 17927) **Fee:** $977.55 **Benefit:** 75% = $733.20 85% = $949.85
38215	SELECTIVE CORONARY ARTERIOGRAPHY - placement of catheters and injection of opaque material (AU 14 - 17914) **Fee:** $322.10 **Benefit:** 75% = $241.60 85% = $294.40
38218	SELECTIVE CORONARY ARTERIOGRAPHY - placement of catheters and injection of opaque material with right or left heart catheterisation, or both (AU 16 - 17916) **Fee:** $531.15 **Benefit:** 75% = $398.40 85% = $503.45
38250	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion of (AU 12 - 17912) **Fee:** $454.90 **Benefit:** 75% = $341.20 85% = $427.20
38253	PERMANENT PACEMAKER, insertion or replacement of (AU 12 - 17912) **Fee:** $181.95 **Benefit:** 75% = $136.50 85% = $154.70

38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (AU 11 - 17911) **Fee:** $190.30 **Benefit:** 75% = $142.75 85% = $162.60
38259	PERMANENT DUAL CHAMBER TRANSVENOUS ELECTRODES, insertion of (AU 12 - 17912) **Fee:** $596.45 **Benefit:** 75% = $447.35 85% = $568.75
	THORACIC SURGERY
38400	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38403 applies **Fee:** $27.40 **Benefit:** 75% = $20.55 85% = $23.30
38403	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample **Fee:** $54.80 **Benefit:** 75% = $41.10 85% = $46.60
38406	PERICARDIUM, paracentesis of (excluding after-care) (AU 6 - 17906) **Fee:** $95.15 **Benefit:** 75% = $71.40 85% = $80.90
38409	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding after-care) (AU 7 - 17907) **Fee:** $95.15 **Benefit:** 75% = $71.40 85% = $80.90
38410	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (AU 7 - 17907) **Fee:** $117.25 **Benefit:** 75% = $87.95 85% = $99.70
38412	PERCUTANEOUS NEEDLE BIOPSY of lung (AU 7 - 17907) **Fee:** $148.95 **Benefit:** 75% = $111.75 85% = $126.65
38415	EMPYEMA, radical operation for, involving resection of rib (AU 13 - 17913) **Fee:** $284.40 **Benefit:** 75% = $213.30 85% = $256.70
38418	THORACOTOMY, exploratory, with or without biopsy (AU 11 - 17911) **Fee:** $682.60 **Benefit:** 75% = $511.95 85% = $654.90
38421	THORACOTOMY, with pulmonary decortication (AU 17 - 17917) **Fee:** $1,091.15 **Benefit:** 75% = $818.40 85% =$1,063.45
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (AU 16 - 17916) **Fee:** $682.60 **Benefit:** 75% = $511.95 85% = $654.90
38427	THORACOPLASTY (complete) - 3 or more ribs (AU 21 - 17921) **Fee:** $842.90 **Benefit:** 75% = $632.20 85% = $815.20
38430	THORACOPLASTY (in stages) - each stage (AU 14 - 17914) **Fee:** $434.40 **Benefit:** 75% = $325.80 85% = $406.70
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter, with or without biopsy (AU 7 - 17907) **Fee:** $177.90 **Benefit:** 75% = $133.45 85% = $151.25
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY (AU 18 - 17918) **Fee:** $1,091.15 **Benefit:** 75% = $818.40 85% =$1,063.45
38440	LUNG, wedge resection of (AU 16 - 17916) **Fee:** $817.05 **Benefit:** 75% = $612.80 85% = $789.35
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (AU 22 - 17922) **Fee:** $1,292.80 **Benefit:** 75% = $969.60 85% =$1,265.10
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (AU 16 - 17916) **Fee:** $842.90 **Benefit:** 75% = $632.20 85% = $815.20
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (AU 28 - 17928) **Fee:** $1,091.75 **Benefit:** 75% = $818.85 85% =$1,064.05

38448	MEDIASTINUM, cervical exploration of, with or without biopsy (AU 10 - 17910) **Fee:** $258.55 **Benefit:** 75% = $193.95 85% = $230.85
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (AU 32 - 17932) **Fee:** $1,526.45 **Benefit:** 75% =$1,144.85 85% =$1,498.75
38450	PERICARDIUM, transthoracic drainage of (AU 14 - 17914) **Fee:** $610.20 **Benefit:** 75% = $457.65 85% = $582.50
38452	PERICARDIUM, sub-xyphoid drainage of (AU 12 - 17912) **Fee:** $408.55 **Benefit:** 75% = $306.45 85% = $380.85
38453	TRACHEAL excision and repair without cardiopulmonary bypass (AU 28 - 17928) **Fee:** $1,225.60 **Benefit:** 75% = $919.20 85% =$1,197.90
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (AU 40 - 17940) **Fee:** $1,657.90 **Benefit:** 75% =$1,243.45 85% =$1,630.20
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:** $1,091.15 **Benefit:** 75% = $818.40 85% =$1,063.45
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (AU 16 - 17916) **Fee:** $1,018.75 **Benefit:** 75% = $764.10 85% = $991.05
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (AU 16 - 17916) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $515.30
38460	STERNAL WIRE OR WIRES, removal of (AU 8 - 17908) **Fee:** $196.10 **Benefit:** 75% = $147.10 85% = $168.40
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (AU 12 - 17912) **Fee:** $232.50 **Benefit:** 75% = $174.40 85% = $204.80
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:** $252.70 **Benefit:** 75% = $189.55 85% = $225.00
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (AU 18 - 17918) **Fee:** $682.35 **Benefit:** 75% = $511.80 85% = $654.65
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (AU 28 - 17928) **Fee:** $1,051.35 **Benefit:** 75% = $788.55 85% =$1,023.65
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (AU 32 - 17932) **Fee:** $1,223.20 **Benefit:** 75% = $917.40 85% =$1,195.50
	PACEMAKER PROCEDURES
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy (AU 11 - 17911) **Fee:** $682.60 **Benefit:** 75% = $511.95 85% = $654.90
38473	PERMANENT PACEMAKER ELECTRODE, insertion by sub-xyphoid approach (AU 11 - 17911) **Fee:** $408.55 **Benefit:** 75% = $306.45 85% = $380.85
	VALVULAR PROCEDURES
38486	AORTIC VALVE, decalcification of (AU 32 - 17932) **Fee:** $1,223.20 **Benefit:** 75% = $917.40 85% =$1,195.50

38487	MITRAL VALVE, open valvotomy of (AU 32 - 17932) **Fee:** $1,223.20 **Benefit:** 75% = $917.40 85% =$1,195.50
38488	VALVE REPLACEMENT with BIOPROSTHESIS, MECHANICAL PROSTHESIS or UNSTENTED XENOGRAFT (AU 32 - 17932) **Fee:** $1,359.65 **Benefit:** 75% =$1,019.75 85% =$1,331.95
38492	VALVE REPLACEMENT WITH ALLOGRAFT, subcoronary or cylindrical implant (AU 36 - 17936) **Fee:** $1,617.45 **Benefit:** 75% =$1,213.10 85% =$1,589.75
38494	VALVE, repair of (AU 32 - 17932) **Fee:** $1,427.25 **Benefit:** 75% =$1,070.45 85% =$1,399.55
‡	*SURGERY FOR ISCHAEMIC HEART DISEASE*
38497	CORONARY ARTERY BYPASS using saphenous vein graft or grafts only, including harvesting of graft material where performed (AU 36 - 17936) **Fee:** $1,458.30 **Benefit:** 75% =$1,093.75 85% =$1,430.60
‡ 38500	CORONARY ARTERY BYPASS using single arterial graft, with or without vein graft or grafts, including harvesting of graft material where performed (AU 36 - 17936) **Fee:** $1,566.90 **Benefit:** 75% =$1,175.20 85% =$1,539.20
‡ 38503	CORONARY ARTERY BYPASS using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of graft material where performed (AU 36 - 17936) **Fee:** $1,701.35 **Benefit:** 75% =$1,276.05 85% =$1,673.65
38506	LEFT VENTRICULAR ANEURYSMECTOMY (AU 32 - 17932) **Fee:** $1,158.35 **Benefit:** 75% = $868.80 85% =$1,130.65
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (AU 40 - 17940) **Fee:** $1,701.35 **Benefit:** 75% =$1,276.05 85% =$1,673.65
	ARRHYTHMIA SURGERY
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (AU 32 - 17932) **Fee:** $1,494.50 **Benefit:** 75% =$1,120.90 85% =$1,466.80
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (AU 36 - 17936) **Fee:** $1,903.00 **Benefit:** 75% =$1,427.25 85% =$1,875.30
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (AU 44 - 17944) **Fee:** $2,042.65 **Benefit:** 75% =$1,532.00 85% =$2,014.95
38521	AUTOMATIC DEFIBRILLATOR, insertion of patches for (AU 10 - 17910) **Fee:** $749.85 **Benefit:** 75% = $562.40 85% = $722.15
38524	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of (AU 10 - 17910) **Fee:** $205.00 **Benefit:** 75% = $153.75 85% = $177.30
	PROCEDURES ON THE THORACIC AORTA
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (AU 42 - 17942) **Fee:** $1,360.05 **Benefit:** 75% =$1,020.05 85% =$1,332.35
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (AU 46 - 17946) **Fee:** $1,768.55 **Benefit:** 75% =$1,326.45 85% =$1,740.85
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (AU 50 - 17950) **Fee:** $2,042.65 **Benefit:** 75% =$1,532.00 85% =$2,014.95

38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (AU 46 - 17946) **Fee:** $1,634.10 **Benefit:** 75% =$1,225.60 85% =$1,606.40
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (AU 50 - 17950) **Fee:** $2,042.65 **Benefit:** 75% =$1,532.00 85% =$2,014.95
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (AU 52 - 17952) **Fee:** $2,311.55 **Benefit:** 75% =$1,733.70 85% =$2,283.85
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass (AU 32 - 17932) **Fee:** $1,158.35 **Benefit:** 75% = $868.80 85% =$1,130.65
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (AU 36 - 17936) **Fee:** $1,292.80 **Benefit:** 75% = $969.60 85% =$1,265.10
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (AU 25 - 17925) **Fee:** $1,415.25 **Benefit:** 75% =$1,061.45 85% =$1,387.55
38574	DEEP HYPOTHERMIA with cardiac arrest, in conjunction with OPEN HEART SURGERY **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $515.30
	CIRCULATORY SUPPORT PROCEDURES
38600	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:** $1,091.15 **Benefit:** 75% = $818.40 85% =$1,063.45
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (AU 13 - 17913) **Fee:** $682.60 **Benefit:** 75% = $511.95 85% = $654.90
38606	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (AU 11 - 17911) **Fee:** $274.10 **Benefit:** 75% = $205.60 85% = $246.40
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (AU 14 - 17914) **Fee:** $341.30 **Benefit:** 75% = $256.00 85% = $313.60
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (AU 14 - 17914) **Fee:** $382.65 **Benefit:** 75% = $287.00 85% = $354.95
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (AU 20 - 17920) **Fee:** $480.20 **Benefit:** 75% = $360.15 85% = $452.50
38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (AU 30 - 17930) **Fee:** $1,091.15 **Benefit:** 75% = $818.40 85% =$1,063.45
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (AU 32 - 17932) **Fee:** $1,360.05 **Benefit:** 75% =$1,020.05 85% =$1,332.35
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (AU 18 - 17918) **Fee:** $543.00 **Benefit:** 75% = $407.25 85% = $515.30
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (AU 20 - 17920) **Fee:** $610.20 **Benefit:** 75% = $457.65 85% = $582.50
‡	***RE-OPERATION***
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (AU 25 - 17925) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $682.60 **Benefit:** 75% = $511.95 85% = $654.90

	MISCELLANEOUS PROCEDURES
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (AU 32 - 17932) **Fee:** $1,360.05 **Benefit:** 75% =$1,020.05 85% =$1,332.35
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (AU 36 - 17936) **Fee:** $1,360.05 **Benefit:** 75% =$1,020.05 85% =$1,332.35
38656	THORACOTOMY or median sternotomy for post-operative bleeding (AU 18 - 17918) **Fee:** $682.60 **Benefit:** 75% = $511.95 85% = $654.90
38659	THORACOTOMY or STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (AU 15 - 17915) **Fee:** $760.20 **Benefit:** 75% = $570.15 85% = $732.50
38662	THORACOTOMY or STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (AU 25 - 17925) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
	CONGENITAL CARDIAC SURGERY
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 26 - 17926) **Fee:** $760.20 **Benefit:** 75% = $570.15 85% = $732.50
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,370.40 **Benefit:** 75% =$1,027.80 85% =$1,342.70
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 32 - 17932) **Fee:** $1,298.00 **Benefit:** 75% = $973.50 85% =$1,270.30
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 36 - 17936) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Ministerial Determination) (AU 32 - 17932) **Fee:** $1,825.45 **Benefit:** 75% =$1,369.10 85% =$1,797.75
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 30 - 17930) **Fee:** $1,215.25 **Benefit:** 75% = $911.45 85% =$1,187.55
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 32 - 17932) **Fee:** $1,065.30 **Benefit:** 75% = $799.00 85% =$1,037.60
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 36 - 17936) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 38718, 38721 or 38724 applies, for congenital heart disease (Ministerial Determination) (AU 32 - 17932) **Fee:** $1,065.30 **Benefit:** 75% = $799.00 85% =$1,037.60
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700, 38703, 38706, 38709, 38712, 38715, 28718, 38721 or 38724 applies, for congenital heart disease (Ministerial Determination) (AU 36 - 17936) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65

38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,065.30 **Benefit:** 75% = $799.00 85% =$1,037.60
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 40 - 17940) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,370.40 **Benefit:** 75% =$1,027.80 85% =$1,342.70
38742	ATRIAL SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,370.40 **Benefit:** 75% =$1,027.80 85% =$1,342.70
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Ministerial Determination) (AU 38 - 17938) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Ministerial Determination) (AU 38 - 17938) **Fee:** $1,903.00 **Benefit:** 75% =$1,427.25 85% =$1,875.30
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Ministerial Determination) (AU 35 - 17935) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Ministerial Determination) (AU 33 - 17933) **Fee:** $1,520.35 **Benefit:** 75% =$1,140.30 85% =$1,492.65
	SUBGROUP 7 - NEUROSURGICAL
‡	**GENERAL**
39000	LUMBAR PUNCTURE (AU 5 - 17905) **Fee:** $53.55 **Benefit:** 75% = $40.20 85% = $45.55
39003	CISTERNAL PUNCTURE **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
39006	VENTRICULAR PUNCTURE (not including burr-hole) **Fee:** $113.55 **Benefit:** 75% = $85.20 85% = $96.55
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (AU 6 - 17906) **Fee:** $42.30 **Benefit:** 75% = $31.75 85% = $36.00
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (AU 11 - 17911) **Fee:** $169.25 **Benefit:** 75% = $126.95 85% = $143.90

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:** $77.85 **Benefit:** 75% = $58.40 85% = $66.20
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (AU 12 - 17912) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $240.10
39018	CEREBROSPINAL FLUID reservoir, insertion of (AU 10 - 17910) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $240.10
	PROCEDURES FOR PAIN RELIEF
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (AU 8 - 17908) **Fee:** $169.25 **Benefit:** 75% = $126.95 85% = $143.90
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (AU 16 - 17916) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (AU 8 - 17908) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (AU 25 - 17925) **Fee:** $1,097.95 **Benefit:** 75% = $823.50 85% =$1,070.25
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:** $70.70 **Benefit:** 75% = $53.05 85% = $60.10
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (AU 7 - 17907) **Fee:** $212.10 **Benefit:** 75% = $159.10 85% = $184.40
39121	PERCUTANEOUS CORDOTOMY (AU 9 - 17909) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
39124	CORDOTOMY OR MYELOTOMY, laminectomy for, or operation for dorsal root entry zone (Drez) lesion (AU 13 - 17913) **Fee:** $1,151.50 **Benefit:** 75% = $863.65 85% =$1,123.80
39125	SPINAL CATHETER, insertion of - for an automated infusion device (AU 8 - 17908) **Fee:** $212.30 **Benefit:** 75% = $159.25 85% = $184.60
39126	AUTOMATED SUBCUTANEOUS INFUSION DEVICE, insertion of (AU 8 - 17908) **Fee:** $257.80 **Benefit:** 75% = $193.35 85% = $230.10
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER FOR PAIN, insertion of (AU 8 - 17908) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
39128	AUTOMATED SUBCUTANEOUS INFUSION DEVICE AND SPINAL CATHETER, insertion of (AU 11 - 17911) **Fee:** $470.05 **Benefit:** 75% = $352.55 85% = $442.35
39130	PERCUTANEOUS EPIDURAL ELECTRODE, insertion of 1 or more of - for spinal stimulation (AU 10 - 17910) **Fee:** $434.70 **Benefit:** 75% = $326.05 85% = $407.00
39131	PERCUTANEOUS EPIDURAL ELECTRODES, management, adjustment, electronic programming and trial of stimulation of, by a medical practitioner - each day **Fee:** $91.00 **Benefit:** 75% = $68.25 85% = $77.35
39133	EPIDURAL STIMULATOR or INTRATHECAL INFUSION DEVICE, revision of (AU 7 - 17907) **Fee:** $113.55 **Benefit:** 75% = $85.20 85% = $96.55
39134	SPINAL NEUROSTIMULATOR RECEIVER or pulse generator, subcutaneous placement of (AU 8 - 17908) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $214.90

39136	PERCUTANEOUS EPIDURAL IMPLANT for management of pain, removal of (AU 7 - 17907) **Fee:** $113.55 **Benefit:** 75% = $85.20 85% = $96.55
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:** $765.90 **Benefit:** 75% = $574.45 85% = $738.20
	PERIPHERAL NERVES
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (AU 9 - 17909) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (AU 10 - 17910) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $304.35
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (AU 11 - 17911) **Fee:** $482.05 **Benefit:** 75% = $361.55 85% = $454.35
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (AU 12 - 17912) **Fee:** $508.80 **Benefit:** 75% = $381.60 85% = $481.10
39312	NERVE TRUNK, (interfasicular), neurolysis of, using microsurgical techniques (AU 11 - 17911) **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $256.15
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (AU 16 - 17916) **Fee:** $733.75 **Benefit:** 75% = $550.35 85% = $706.05
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (AU 12 - 17912) **Fee:** $455.25 **Benefit:** 75% = $341.45 85% = $427.55
39321	NERVE, transposition of (AU 8 - 17908) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
39323	PERCUTANEOUS NEUROTOMY by cryoneurotomy or radiofrequency lesion generator, not being a service to which another item applies (AU 8 - 17908) **Fee:** $196.10 **Benefit:** 75% = $147.10 85% = $168.40
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (AU 8 - 17908) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation (AU 10 - 17910) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (AU 7 - 17907) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (AU 7 - 17907) **Fee:** $196.10 **Benefit:** 75% = $147.10 85% = $168.40
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (AU 11 - 17911) **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $256.15
	CRANIAL NERVES
39500	VESTIBULAR NERVE, section of, via posterior fossa (AU 24 - 17924) **Fee:** $905.15 **Benefit:** 75% = $678.90 85% = $877.45
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (AU 28 - 17928) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50

	CRANIO-CEREBRAL INJURIES
39600	Intracranial haemorrhage, burr-hole craniotomy for - including burr holes (AU 11 - 17911) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (AU 18 - 17918) **Fee:** $851.60 **Benefit:** 75% = $638.70 85% = $823.90
39606	FRACTURED SKULL, depressed or comminuted, operation for (AU 12 - 17912) **Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $540.00
39609	FRACTURED SKULL, compound, without dural penetration, operation for (AU 12 - 17912) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (AU 14 - 17914) **Fee:** $798.05 **Benefit:** 75% = $598.55 85% = $770.35
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (AU 16 - 17916) **Fee:** $851.60 **Benefit:** 75% = $638.70 85% = $823.90
	INTRACRANIAL NEOPLASMS
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (AU 27 - 17927) **Fee:** $396.35 **Benefit:** 75% = $297.30 85% = $368.65
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (AU 10 - 17910) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (AU 18 - 17918) **Fee:** $792.65 **Benefit:** 75% = $594.50 85% = $764.95
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Group applies (AU 25 - 17925) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Group applies (AU 25 - 17925) **Fee:** $2,040.60 **Benefit:** 75% =$1,530.45 85% =$2,012.90
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (AU 25 - 17925) **Fee:** $1,413.95 **Benefit:** 75% =$1,060.50 85% =$1,386.25
39718	ARACHNOIDAL CYST, craniotomy for (AU 15 - 17915) **Fee:** $621.30 **Benefit:** 75% = $466.00 85% = $593.60
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (AU 16 - 17916) **Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $540.00
	CEREBROVASCULAR DISEASE
39800	ANEURYSM, clipping or reinforcement of sac (AU 28 - 17928) **Fee:** $2,035.25 **Benefit:** 75% =$1,526.45 85% =$2,007.55
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (AU 32 - 17932) **Fee:** $2,035.25 **Benefit:** 75% =$1,526.45 85% =$2,007.55
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (AU 24 - 17924) **Fee:** $915.85 **Benefit:** 75% = $686.90 85% = $888.15

39809	ARTERIOVENOUS MALFORMATION, craniotomy and direct embolisation of (AU 32 - 17932) **Fee:** $1,017.60 **Benefit:** 75% = $763.20 85% = $989.90
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (AU 10 - 17910) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (AU 40 - 17940) **Fee:** $1,301.50 **Benefit:** 75% = $976.15 85% =$1,273.80
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery or saphenous vein graft (AU 32 - 17932) **Fee:** $1,301.50 **Benefit:** 75% = $976.15 85% =$1,273.80
	INFECTION
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (AU 10 - 17910) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
39903	INTRACRANIAL ABSCESS, excision of (AU 17 - 17917) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (AU 10 - 17910) **Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $540.00
	CEREBRO-SPINAL FLUID CIRCULATION DISORDERS
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (AU 15 - 17915) **Fee:** $653.40 **Benefit:** 75% = $490.05 85% = $625.70
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (AU 14 - 17914) **Fee:** $653.40 **Benefit:** 75% = $490.05 85% = $625.70
40006	LUMBAR SHUNT DIVERSION, insertion of (AU 13 - 17913) **Fee:** $514.15 **Benefit:** 75% = $385.65 85% = $486.45
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (AU 12 - 17912) **Fee:** $374.90 **Benefit:** 75% = $281.20 85% = $347.20
40012	THIRD VENTRICULOSTOMY (AU 15 - 17915) **Fee:** $733.75 **Benefit:** 75% = $550.35 85% = $706.05
40015	SUBTEMPORAL DECOMPRESSION (AU 26 - 17926) **Fee:** $454.90 **Benefit:** 75% = $341.20 85% = $427.20
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (AU 6 - 17906) **Fee:** $113.55 **Benefit:** 75% = $85.20 85% = $96.55
	CONGENITAL DISORDERS
40100	MENINGOCELE, excision and closure of (AU 13 - 17913) **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (AU 15 - 17915) **Fee:** $723.05 **Benefit:** 75% = $542.30 85% = $695.35
40106	ARNOLD-CHIARI MALFORMATION, decompression of (AU 35 - 17935) **Fee:** $733.75 **Benefit:** 75% = $550.35 85% = $706.05
40109	ENCEPHALOCOELE, excision and closure of (AU 34 - 17934) **Fee:** $792.65 **Benefit:** 75% = $594.50 85% = $764.95
40112	TETHERED CORD, release of, including lipomeningocoele or diastematomyelia (AU 35 - 17935) **Fee:** $1,017.60 **Benefit:** 75% = $763.20 85% = $989.90

40115	CRANIOSTENOSIS, operation for - single suture (AU 17 - 17917) **Fee:** $514.15 **Benefit:** 75% = $385.65 85% = $486.45
40118	CRANIOSTENOSIS, operation for - more than 1 suture (AU 20 - 17920) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50
	SPINAL DISORDERS
40300	INTERVERTEBRAL DISC OR DISCS, laminectomy for removal of (AU 12 - 17912) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical discectomy of (AU 12 - 17912) **Fee:** $682.35 **Benefit:** 75% = $511.80 85% = $654.65
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, laminectomy for - 1 level (AU 13 - 17913) **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
40306	SPINAL STENOSIS, laminectomy for, involving more than 1 vertebral interspace (disc level) (AU 16 - 17916) **Fee:** $1,022.95 **Benefit:** 75% = $767.25 85% = $995.25
40309	EXTRADURAL TUMOUR OR ABSCESS, laminectomy for (AU 12 - 17912) **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
40312	INTRADURAL LESION, laminectomy for, not being a service to which another item in this Group applies (AU 13 - 17913) **Fee:** $1,044.40 **Benefit:** 75% = $783.30 85% =$1,016.70
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (AU 29 - 17929) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, laminectomy and radical excision of (AU 14 - 17914) **Fee:** $1,413.95 **Benefit:** 75% =$1,060.50 85% =$1,386.25
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (AU 18 - 17918) **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
40324	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (AU 18 - 17918) **Fee:** $455.25 **Benefit:** 75% = $341.45 85% = $427.55
40327	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare **Fee:** $455.25 **Benefit:** 75% = $341.45 85% = $427.55
40330	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots, with or without laminectomy (AU 16 - 17916) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50
40333	CERVICAL DISCECTOMY (ANTERIOR), without fusion (AU 19 - 17919) **Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $540.00
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCASE) - 1 disc (AU 8 - 17908) *(See para T8.25 of explanatory notes to this Category)* **Fee:** $225.00 **Benefit:** 75% = $168.75 85% = $197.30
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (AU 25 - 17925) **Fee:** $1,130.10 **Benefit:** 75% = $847.60 85% =$1,102.40
40342	HYDROMYELIA, craniotomy and laminectomy for, with cavity packing and CSF shunt (AU 25 - 17925) **Fee:** $1,044.40 **Benefit:** 75% = $783.30 85% =$1,016.70

	SKULL RECONSTRUCTION
40600	CRANIOPLASTY, reconstructive (AU 16 - 17916) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50
	EPILEPSY
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (AU 25 - 17925) **Fee:** $1,242.55 **Benefit:** 75% = $931.95 85% =$1,214.85
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (AU 23 - 17923) **Fee:** $1,044.40 **Benefit:** 75% = $783.30 85% =$1,016.70
40706	HEMISPHERECTOMY for intractible epilepsy (AU 40 - 17940) **Fee:** $1,526.40 **Benefit:** 75% =$1,144.80 85% =$1,498.70
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (AU 15 - 17915) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (AU 21 - 17921) **Fee:** $744.45 **Benefit:** 75% = $558.35 85% = $716.75
	STEREOTACTIC PROCEDURES
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (AU 17 - 17917) **Fee:** $454.90 **Benefit:** 75% = $341.20 85% = $427.20
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:** $1,243.40 **Benefit:** 75% = $932.55 85% =$1,215.70
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which another item in this Group applies (AU 17 - 17917) **Fee:** $851.60 **Benefit:** 75% = $638.70 85% = $823.90
	SUBGROUP 8 - EAR, NOSE AND THROAT
41500	EAR, foreign body in, removal of, otherwise than by simple syringing (AU 4 - 17904) **Fee:** $58.75 **Benefit:** 75% = $44.10 85% = $49.95
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (AU 6 - 17906) **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60
41506	AURAL POLYP, removal of (AU 4 - 17904) **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $116.10 **Benefit:** 75% = $87.10 85% = $98.70
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (AU 9 - 17909) **Fee:** $417.35 **Benefit:** 75% = $313.05 85% = $389.65
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530, 41548, 41557, 41560 or 41563 applies (AU 7 - 17907) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $273.85 **Benefit:** 75% = $205.40 85% = $246.15

41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (AU 12 - 17912) **Fee:** $661.55 **Benefit:** 75% = $496.20 85% = $633.85
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (AU 12 - 17912) **Fee:** $704.25 **Benefit:** 75% = $528.20 85% = $676.55
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557, 41560 and 41563 apply (AU 9 - 17909) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $203.45 **Benefit:** 75% = $152.60 85% = $175.75
41527	MYRINGOPLASTY, trans-canal approach (Rosen incision) (AU 11 - 17911) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
41530	MYRINGOPLASTY, post-aural or endaural approach with or without mastoid inspection (AU 12 - 17912) **Fee:** $681.80 **Benefit:** 75% = $511.35 85% = $654.10
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (AU 12 - 17912) **Fee:** $815.10 **Benefit:** 75% = $611.35 85% = $787.40
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (AU 14 - 17914) **Fee:** $912.90 **Benefit:** 75% = $684.70 85% = $885.20
41539	OSSICULAR CHAIN RECONSTRUCTION (AU 12 - 17912) **Fee:** $776.30 **Benefit:** 75% = $582.25 85% = $748.60
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (AU 13 - 17913) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
41545	MASTOIDECTOMY (CORTICAL) (AU 12 - 17912) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
41548	OBLITERATION OF THE MASTOID CAVITY (AU 10 - 17910) **Fee:** $492.75 **Benefit:** 75% = $369.60 85% = $465.05
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (AU 16 - 17916) **Fee:** $1,134.60 **Benefit:** 75% = $850.95 85% =$1,106.90
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (AU 18 - 17918) **Fee:** $1,336.75 **Benefit:** 75% =$1,002.60 85% =$1,309.05
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (AU 13 - 17913) **Fee:** $776.30 **Benefit:** 75% = $582.25 85% = $748.60
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (AU 13 - 17913) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (AU 14 - 17914) **Fee:** $1,053.05 **Benefit:** 75% = $789.80 85% =$1,025.35
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (AU 16 - 17916) **Fee:** $775.95 **Benefit:** 75% = $582.00 85% = $748.25
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (AU 13 - 17913) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (AU 12 - 17912) **Fee:** $735.80 **Benefit:** 75% = $551.85 85% = $708.10
41575	CEREBELLO - PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach - transmastoid, translabyrinthine or retromastoid procedure (including after-care) (AU 39 - 17939) **Fee:** $1,734.80 **Benefit:** 75% =$1,301.10 85% =$1,707.10

41578	CEREBELLO - PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including after-care) **Fee:** $1,734.80 **Benefit:** 75% =$1,301.10 85% =$1,707.10
41581	SKULL BASE TUMOUR, removal of by infra-temporal approach (AU 40 - 17940) **Fee:** $1,995.35 **Benefit:** 75% =$1,496.55 85% =$1,967.65
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (AU 28 - 17928) **Fee:** $1,369.35 **Benefit:** 75% =$1,027.05 85% =$1,341.65
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (AU 32 - 17932) **Fee:** $1,864.95 **Benefit:** 75% =$1,398.75 85% =$1,837.25
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (AU 12 - 17912) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (AU 22 - 17922) **Fee:** $1,108.55 **Benefit:** 75% = $831.45 85% =$1,080.85
41596	RETROLABYRINTHINE VESTIBULAR and/or COCHLEAR NERVE SECTION (AU 26 - 17926) **Fee:** $1,238.95 **Benefit:** 75% = $929.25 85% =$1,211.25
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (AU 23 - 17923) **Fee:** $1,238.95 **Benefit:** 75% = $929.25 85% =$1,211.25
41602	FENESTRATION OPERATION - each ear (AU 11 - 17911) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
41605	VENOUS GRAFT TO FENESTRATION CAVITY (AU 12 - 17912) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
41608	STAPEDECTOMY (AU 11 - 17911) **Fee:** $776.30 **Benefit:** 75% = $582.25 85% = $748.60
41611	STAPES MOBILISATION (AU 10 - 17910) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
41614	ROUND WINDOW SURGERY including repair of cochleotomy (AU 11 - 17911) **Fee:** $776.30 **Benefit:** 75% = $582.25 85% = $748.60
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (AU 23 - 17923) **Fee:** $1,349.80 **Benefit:** 75% =$1,012.35 85% =$1,322.10
41620	GLOMUS TUMOUR, transtympanic removal of (AU 12 - 17912) **Fee:** $587.30 **Benefit:** 75% = $440.50 85% = $559.60
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (AU 13 - 17913) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding after-care) (AU 7 - 17907) **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25
41629	MIDDLE EAR, EXPLORATION OF (AU 9 - 17909) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (AU 7 - 17907) **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (AU 10 - 17910) **Fee:** $815.10 **Benefit:** 75% = $611.35 85% = $787.40

41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (AU 16 - 17916) **Fee:** $1,017.25 **Benefit:** 75% = $762.95 85% = $989.55
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (AU 6 - 17906) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (AU 6 - 17906) **Fee:** $101.70 **Benefit:** 75% = $76.30 85% = $86.45
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (AU 7 - 17907) **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (AU 7 - 17907) **Fee:** $78.30 **Benefit:** 75% = $58.75 85% = $66.60
41653	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (AU 6 - 17906) **Fee:** $51.30 **Benefit:** 75% = $38.50 85% = $43.65
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding after-care) (AU 8 - 17908) **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (AU 6 - 17906) **Fee:** $55.35 **Benefit:** 75% = $41.55 85% = $47.05
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of *(See para T8.28 of explanatory notes to this Category)* **Fee:** $58.75 **Benefit:** 75% = $44.10 85% = $49.95
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (AU 7 - 17907) *(See para T8.28 of explanatory notes to this Category)* **Fee:** $122.85 **Benefit:** 75% = $92.15 85% = $104.45 **Fee:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (AU 9 - 17909) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $316.55
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (AU 6 - 17906) **Fee:** $71.55 **Benefit:** 75% = $53.70 85% = $60.85
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (AU 7 - 17907) **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (AU 7 - 17907) **Fee:** $116.10 **Benefit:** 75% = $87.10 85% = $98.70
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the post-operative period of a nasal operation (AU 6 - 17906) **Fee:** $83.45 **Benefit:** 75% = $62.60 85% = $70.95
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (AU 6 - 17906) **Fee:** $51.30 **Benefit:** 75% = $38.50 85% = $43.65
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (AU 6 - 17906) **Fee:** $97.20 **Benefit:** 75% = $72.90 85% = $82.65

41692	TURBINATES, submucous resection of, unilateral (AU 8 - 17908) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
41695	TURBINATES, cryotherapy to (AU 6 - 17906) **Fee:** $71.20 **Benefit:** 75% = $53.40 85% = $60.55
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (AU 6 - 17906) **Fee:** $23.20 **Benefit:** 75% = $17.40 85% = $19.75
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (AU 6 - 17906) **Fee:** $65.50 **Benefit:** 75% = $49.15 85% = $55.70
41704	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (AU 6 - 17906) **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
41707	MAXILLARY ARTERY, transantral ligation of (AU 9 - 17909) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
41710	ANTROSTOMY (RADICAL) (AU 9 - 17909) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (AU 10 - 17910) **Fee:** $432.00 **Benefit:** 75% = $324.00 85% = $404.30
41716	ANTRUM, intranasal operation on, or removal of foreign body from (AU 8 - 17908) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
41719	ANTRUM, drainage of, through tooth socket (AU 7 - 17907) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15
41722	ORO-ANTRAL FISTULA, plastic closure of (AU 11 - 17911) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (AU 10 - 17910) **Fee:** $319.50 **Benefit:** 75% = $239.65 85% = $291.80
41728	LATERAL RHINOTOMY with removal of tumour (AU 12 - 17912) **Fee:** $639.05 **Benefit:** 75% = $479.30 85% = $611.35
‡ 41731	FRONTO-NASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (AU 9 - 17909) **Fee:** $553.50 **Benefit:** 75% = $415.15 85% = $525.80
41734	RADICAL FRONTO-ETHMOIDECTOMY with osteoplastic flap (AU 13 - 17913) **Fee:** $722.30 **Benefit:** 75% = $541.75 85% = $694.60
41737	FRONTAL SINUS OR ETHMOIDAL SINUSES, intranasal operation on (AU 9 - 17909) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $316.55
41740	FRONTAL SINUS, catheterisation of (AU 6 - 17906) **Fee:** $41.85 **Benefit:** 75% = $31.40 85% = $35.60
41743	FRONTAL SINUS, trephine of (AU 6 - 17906) **Fee:** $240.30 **Benefit:** 75% = $180.25 85% = $212.60
41746	FRONTAL SINUS, radical obliteration of (AU 10 - 17910) **Fee:** $553.50 **Benefit:** 75% = $415.15 85% = $525.80
41749	ETHMOIDAL SINUSES, external operation on (AU 10 - 17910) **Fee:** $432.00 **Benefit:** 75% = $324.00 85% = $404.30
41752	SPHENOIDAL SINUS, intranasal operation on (AU 10 - 17910) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90

41755	EUSTACHIAN TUBE, catheterisation of (AU 6 - 17906) **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15
41758	DIVISION OF PHARYNGEAL ADHESIONS (AU 7 - 17907) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15
41761	POST-NASAL SPACE, direct examination of, with or without biopsy (AU 7 - 17907) **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60
‡ 41764	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures (AU 7 - 17907) **Fee:** $87.40 **Benefit:** 75% = $65.55 85% = $74.30
41767	NASOPHARYNGEAL ANGIOFIBROMA, transpalatal removal (AU 12 - 17912) **Fee:** $521.65 **Benefit:** 75% = $391.25 85% = $493.95
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (AU 16 - 17916) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (AU 14 - 17914) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (AU 10 - 17910) **Fee:** $417.35 **Benefit:** 75% = $313.05 85% = $389.65
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (AU 6 - 17906) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (AU 12 - 17912) **Fee:** $678.15 **Benefit:** 75% = $508.65 85% = $650.45
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (AU 14 - 17914) **Fee:** $841.20 **Benefit:** 75% = $630.90 85% = $813.50
41786	PHARYNGEAL FLAP or PHARYNGOPLASTY, with or without tonsillectomy (AU 15 - 17915) **Fee:** $524.90 **Benefit:** 75% = $393.70 85% = $497.20
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (AU 7 - 17907) **Fee:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15 **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (AU 8 - 17908) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40 **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (AU 9 - 17909) **Fee:** $81.00 **Benefit:** 75% = $60.75 85% = $68.85 **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25
41800 G 41801 S	ADENOIDS, removal of (AU 6 - 17906) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15 **Fee:** $116.10 **Benefit:** 75% = $87.10 85% = $98.70
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (AU 7 - 17907) **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55
41807	PERITONSILLAR ABSCESS (quinsy), incision of (AU 7 - 17907) **Fee:** $49.95 **Benefit:** 75% = $37.50 85% = $42.50
41810	UVULOTOMY or UVULECTOMY (AU 6 - 17906) **Fee:** $25.40 **Benefit:** 75% = $19.05 85% = $21.60
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (AU 8 - 17908) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10

41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (AU 6 - 17906) **Fee:** $132.30 **Benefit:** 75% = $99.25 85% = $112.50
41819	OESOPHAGEAL AND ANASTOMOTIC STRICTURE, endoscopic dilatation of (AU 7 - 17907) **Fee:** $248.60 **Benefit:** 75% = $186.45 85% = $220.90
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (AU 7 - 17907) **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (AU 7 - 17907) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (AU 6 - 17906) **Fee:** $37.15 **Benefit:** 75% = $27.90 85% = $31.60
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (AU 8 - 17908) **Fee:** $254.25 **Benefit:** 75% = $190.70 85% = $226.55
41834	LARYNGECTOMY (TOTAL) (AU 20 - 17920) **Fee:** $918.05 **Benefit:** 75% = $688.55 85% = $890.35
41837	VERTICAL HEMI-LARYNGECTOMY including tracheostomy (AU 17 - 17917) **Fee:** $880.30 **Benefit:** 75% = $660.25 85% = $852.60
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (AU 21 - 17921) **Fee:** $1,082.45 **Benefit:** 75% = $811.85 85% =$1,054.75
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (AU 20 - 17920) **Fee:** $951.80 **Benefit:** 75% = $713.85 85% = $924.10
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (AU 8 - 17908) *(See para T8.29 of explanatory notes to this Category)* **Fee:** $132.30 **Benefit:** 75% = $99.25 85% = $112.50
41849	LARYNX, direct examination of, with biopsy (AU 8 - 17908) **Fee:** $194.40 **Benefit:** 75% = $145.80 85% = $166.70
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (AU 9 - 17909) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
41855	MICROLARYNGOSCOPY (AU 8 - 17908) **Fee:** $205.20 **Benefit:** 75% = $153.90 85% = $177.50
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (AU 10 - 17910) *(See para T8.30 of explanatory notes to this Category)* **Fee:** $352.10 **Benefit:** 75% = $264.10 85% = $324.40
41861	MICROLARYNGOSCOPY with removal of papillomata by laser surgery (AU 13 - 17913) **Fee:** $430.35 **Benefit:** 75% = $322.80 85% = $402.65
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (AU 9 - 17909) **Fee:** $290.25 **Benefit:** 75% = $217.70 85% = $262.55
41867	MICROLARYNGOSCOPY with arytenoidectomy (AU 13 - 17913) **Fee:** $436.90 **Benefit:** 75% = $327.70 85% = $409.20
41870	TEFLON INJECTION INTO VOCAL CORD (AU 9 - 17909) **Fee:** $324.00 **Benefit:** 75% = $243.00 85% = $296.30
41873	LARYNX, FRACTURED, operation for (AU 15 - 17915) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80

41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (AU 13 - 17913) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (AU 17 - 17917) **Fee:** $678.15 **Benefit:** 75% = $508.65 85% = $650.45
41882 G 41883 S	TRACHEOSTOMY (AU 10 - 17910) **Fee:** $130.95 **Benefit:** 75% = $98.25 85% = $111.35 **Fee:** $170.10 **Benefit:** 75% = $127.60 85% = $144.60
41886	TRACHEA, removal of foreign body in (AU 7 - 17907) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
41889	BRONCHOSCOPY, as an independent procedure (AU 7 - 17907) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (AU 8 - 17908) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
41895	BRONCHUS, removal of foreign body in (AU 9 - 17909) **Fee:** $261.90 **Benefit:** 75% = $196.45 85% = $234.20
41898	FIBREOPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or broncho-alveolar lavage, with or without the use of interventional imaging (AU 8 - 17908) **Fee:** $183.05 **Benefit:** 75% = $137.30 85% = $155.60
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (AU 15 - 17915) **Fee:** $429.45 **Benefit:** 75% = $322.10 85% = $401.75
41904	BRONCHOSCOPY with dilatation of tracheal stricture (AU 7 - 17907) **Fee:** $175.50 **Benefit:** 75% = $131.65 85% = $149.20
41907	NASAL SEPTUM BUTTON, insertion of (AU 6 - 17906) **Fee:** $87.40 **Benefit:** 75% = $65.55 85% = $74.30
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (AU 16 - 17916) **Fee:** $278.00 **Benefit:** 75% = $208.50 85% = $250.30
	SUBGROUP 9 - OPHTHALMOLOGY
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (AU 5 - 17905) **Fee:** $72.85 **Benefit:** 75% = $54.65 85% = $61.95
42506	EYE, ENUCLEATION OF, with or without sphere implant (AU 8 - 17908) **Fee:** $342.80 **Benefit:** 75% = $257.10 85% = $315.10
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (AU 9 - 17909) **Fee:** $433.85 **Benefit:** 75% = $325.40 85% = $406.15
42512	GLOBE, EVISCERATION OF (AU 8 - 17908) **Fee:** $342.80 **Benefit:** 75% = $257.10 85% = $315.10
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (AU 9 - 17909) **Fee:** $433.85 **Benefit:** 75% = $325.40 85% = $406.15
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET (AU 9 - 17909) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05

42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (AU 16 - 17916) **Fee:** $856.95 **Benefit:** 75% = $642.75 85% = $829.25
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (AU 7 - 17907) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (AU 11 - 17911) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (AU 9 - 17909) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (AU 8 - 17908) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (AU 11 - 17911) **Fee:** $594.50 **Benefit:** 75% = $445.90 85% = $566.80
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (AU 12 - 17912) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
42542	ORBIT, EXPLORATION OF, with removal of tumour or of foreign body (AU 10 - 17910) **Fee:** $358.85 **Benefit:** 75% = $269.15 85% = $331.15
42545	ORBIT, decompression of, for dysthyroid eye disease, 2 or more walls, 1 eye (AU 16 - 17916) **Fee:** $910.50 **Benefit:** 75% = $682.90 85% = $882.80
42548	OPTIC NERVE MENINGES, incision of (AU 17 - 17917) **Fee:** $540.95 **Benefit:** 75% = $405.75 85% = $513.25
42551	EYEBALL, PERFORATING WOUND OF, not involving intraocular structures - repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (AU 10 - 17910) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue - repair (AU 12 - 17912) **Fee:** $524.90 **Benefit:** 75% = $393.70 85% = $497.20
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous - repair (AU 12 - 17912) **Fee:** $733.75 **Benefit:** 75% = $550.35 85% = $706.05
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (AU 10 - 17910) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (AU 11 - 17911) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (AU 10 - 17910) **Fee:** $524.90 **Benefit:** 75% = $393.70 85% = $497.20
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (AU 12 - 17912) **Fee:** $733.75 **Benefit:** 75% = $550.35 85% = $706.05
42572	ORBITAL ABSCESS OR CYST, drainage of (AU 6 - 17906) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
42575	TARSAL CYST, extirpation of (AU 6 - 17906) **Fee:** $58.90 **Benefit:** 75% = $44.20 85% = $50.10
42578	TARSAL CARTILAGE, excision of (AU 8 - 17908) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $304.35
42581	ECTROPION OR ENTROPION, tarsal cauterisation of **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05

42584	TARSORRHAPHY (AU 8 - 17908) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
42587	CRYOTHERAPY or ELECTROLYSIS EPILATION for trichiasis - each eyelid (AU 6 - 17906) **Fee:** $36.95 **Benefit:** 75% = $27.75 85% = $31.45
42590	CANTHOPLASTY, medial or lateral (AU 9 - 17909) **Fee:** $241.00 **Benefit:** 75% = $180.75 85% = $213.30
42593	LACRIMAL GLAND, excision of palpebral lobe (AU 8 - 17908) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
42596	LACRIMAL SAC, excision of, or operation on (AU 8 - 17908) **Fee:** $358.85 **Benefit:** 75% = $269.15 85% = $331.15
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (AU 10 - 17910) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (AU 8 - 17908) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
42605	LACRIMAL CANALICULUS, immediate repair of (AU 8 - 17908) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $304.35
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (AU 10 - 17910) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
42611	NASOLACRIMAL TUBE (unilateral) replacement of, under general anaesthesia, or lacrimal passages, probing for obstruction, unilateral or bilateral, with or without lavage (AU 4 - 17904) **Fee:** $102.85 **Benefit:** 75% = $77.15 85% = $87.45
42614	LACRIMAL PASSAGES, lavage of, unilateral, not being a service associated with a service to which item 42611 applies (excluding after-care) (AU 4 - 17904) **Fee:** $34.30 **Benefit:** 75% = $25.75 85% = $29.20
42617	PUNCTUM SNIP operation (AU 4 - 17904) **Fee:** $97.50 **Benefit:** 75% = $73.15 85% = $82.90
42620	PUNCTUM, occlusion of, by use of a plug (AU 5 - 17905) **Fee:** $37.50 **Benefit:** 75% = $28.15 85% = $31.90
42623	DACRYOCYSTORHINOSTOMY (AU 11 - 17911) **Fee:** $498.10 **Benefit:** 75% = $373.60 85% = $470.40
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (AU 11 - 17911) **Fee:** $803.40 **Benefit:** 75% = $602.55 85% = $775.70
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (AU 12 - 17912) **Fee:** $605.20 **Benefit:** 75% = $453.90 85% = $577.50
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (AU 6 - 17906) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (AU 9 - 17909) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
42638	CONJUNCTIVAL GRAFT OVER CORNEA (AU 7 - 17907) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $240.10
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (AU 11 - 17911) **Fee:** $348.15 **Benefit:** 75% = $261.15 85% = $320.45
42644	CORNEA OR SCLERA, removal of imbedded foreign body from (excluding after-care) (AU 8 - 17908) **Fee:** $51.40 **Benefit:** 75% = $38.55 85% = $43.70

42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (AU 8 - 17908) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding after-care) (AU 8 - 17908) **Fee:** $51.40 **Benefit:** 75% = $38.55 85% = $43.70
‡ 42653	CORNEA, transplantation of, full thickness (AU 13 - 17913) **Fee:** $953.35 **Benefit:** 75% = $715.05 85% = $925.65
‡ 42656	CORNEA, transplantation of, where there have been 2 previous graft operations (AU 13 - 17913) **Fee:** $1,189.00 **Benefit:** 75% = $891.75 85% =$1,161.30
‡ 42659	CORNEA, transplantation of, superficial or lamellar (AU 11 - 17911) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
42662	SCLERA, transplantation of, full thickness, including collection of donor material (AU 15 - 17915) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (AU 14 - 17914) **Fee:** $428.45 **Benefit:** 75% = $321.35 85% = $400.75
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (AU 6 - 17906) **Fee:** $53.55 **Benefit:** 75% = $40.20 85% = $45.55
42671	REFRACTIVE KERATOPLASTY with penetrating incisions (excluding radial keratotomy) following corneal grafting or intraocular operation INCLUDING ANY MEASUREMENTS AND CALCULATIONS associated with the procedure (AU 10 - 17910) *(See para T8.31 of explanatory notes to this Category)* **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
42674	CORNEAL INCISIONS, non penetrating, for the correction of astigmatism following surgery of anterior chamber or corneal grafting, and including associated ultrasound pachymetry of corneal thickness, with or without compression sutures (AU 10 - 17910) **Fee:** $321.35 **Benefit:** 75% = $241.05 85% = $293.65
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS - each attendance at which treatment is given including any associated consultation (AU 4 - 17904) **Fee:** $43.40 **Benefit:** 75% = $32.55 85% = $36.90
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO2 or N20 (AU 7 - 17907) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day hospital facility (AU 6 - 17906) **Fee:** $85.70 **Benefit:** 75% = $64.30 85% = $72.85
42686	PTERYGIUM, removal of (AU 6 - 17906) **Fee:** $194.95 **Benefit:** 75% = $146.25 85% = $167.25
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (AU 6 - 17906) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
42692	LIMBIC TUMOUR, removal of (AU 7 - 17907) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy (AU 12 - 17912) **Fee:** $321.35 **Benefit:** 75% = $241.05 85% = $293.65
42698	LENS EXTRACTION (AU 11 - 17911) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
42701	ARTIFICIAL LENS, insertion of (AU 11 - 17911) **Fee:** $310.65 **Benefit:** 75% = $233.00 85% = $282.95

42704	ARTIFICIAL LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (AU 9 - 17909) **Fee:** $332.05 **Benefit:** 75% = $249.05 85% = $304.35
42707	ARTIFICIAL LENS, REMOVAL of and REPLACEMENT with a different lens (AU 12 - 17912) **Fee:** $567.70 **Benefit:** 75% = $425.80 85% = $540.00
42710	ARTIFICIAL LENS, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (AU 15 - 17915) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (AU 11 - 17911) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $240.10
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (AU 11 - 17911) **Fee:** $851.60 **Benefit:** 75% = $638.70 85% = $823.90
42719	CAPSULECTOMY OR REMOVAL OF VITREOUS via the anterior chamber by any method, not being a service associated with any other intraocular operation on that eye (AU 9 - 17909) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
42722	CAPSULECTOMY by posterior chamber sclerotomy OR REMOVAL OF VITREOUS or VITREOUS BANDS from the anterior chamber by posterior chamber sclerotomy, by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with any other intraocular operation on that eye - 1 or both procedures (AU 15 - 17915) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $404.30 **Benefit:** 75% = $303.25 85% = $376.60
42725	VITRECTOMY by posterior chamber sclerotomy - including the removal of vitreous, division of bands or removal of pre-retinal membranes by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with any other intraocular operation on that eye, other than a service to which item 42728 applies (AU 25 - 17925) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $953.35 **Benefit:** 75% = $715.05 85% = $925.65
42728	CRYOTHERAPY OF RETINA or other intraocular structures with an internal probe, being a service associated with a service to which item 42725 applies (AU 9 - 17909) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
42731	CAPSULECTOMY or LENSECTOMY by posterior chamber sclerotomy in conjunction with the removal of vitreous or division of vitreous bands or removal of pre-retinal membrane from the posterior chamber by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with any other intraocular operation (AU 25 - 17925) *(See para T8.32 of explanatory notes to this Category)* **Fee:** $1,081.90 **Benefit:** 75% = $811.45 85% =$1,054.20
42734	CAPSULOTOMY, other than by laser (AU 9 - 17909) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
42737	NEEDLING OF POSTERIOR CAPSULE (AU 8 - 17908) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
42740	PARACENTESIS OF ANTERIOR OR POSTERIOR CHAMBER OR BOTH, for the injection of therapeutic substances, or the removal of aqueous or vitreous for diagnostic purposes, 1 or more of (AU 9 - 17909) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (AU 7 - 17907) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
42746	GLAUCOMA, filtering operation for (AU 10 - 17910) **Fee:** $680.20 **Benefit:** 75% = $510.15 85% = $652.50
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (AU 10 - 17910) **Fee:** $851.60 **Benefit:** 75% = $638.70 85% = $823.90

42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (AU 18 - 17918) **Fee:** $953.35 **Benefit:** 75% = $715.05 85% = $925.65
42755	GLAUCOMA, removal of Molteno valve (AU 8 - 17908) **Fee:** $117.85 **Benefit:** 75% = $88.40 85% = $100.20
42758	GONIOTOMY (AU 10 - 17910) **Fee:** $498.10 **Benefit:** 75% = $373.60 85% = $470.40
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (AU 9 - 17909) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (AU 10 - 17910) **Fee:** $369.55 **Benefit:** 75% = $277.20 85% = $341.85
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (AU 12 - 17912) **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
42770	CYCLODIATHERMY OR CYCLOCRYOTHERAPY (AU 8 - 17908) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $182.30
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (AU 11 - 17911) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
42776	DETACHED RETINA, buckling or resection operation for (AU 15 - 17915) **Fee:** $953.35 **Benefit:** 75% = $715.05 85% = $925.65
42779	DETACHED RETINA, revision operation for (AU 15 - 17915) **Fee:** $1,189.00 **Benefit:** 75% = $891.75 85% =$1,161.30
42782	LASER TRABECULOPLASTY - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (AU 6 - 17906) **Fee:** $321.35 **Benefit:** 75% = $241.05 85% = $293.65
42785	LASER IRIDOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (AU 6 - 17906) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05
42788	LASER CAPSULOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (AU 6 - 17906) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05
42791	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (AU 6 - 17906) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05
42794	DIVISION OF SUTURE BY LASER - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (AU 5 - 17905) **Fee:** $48.20 **Benefit:** 75% = $36.15 85% = $41.00
42797	LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (AU 5 - 17905) **Fee:** $48.20 **Benefit:** 75% = $36.15 85% = $41.00
42800	PTERYGIUM, removal by laser in 1 or more stages (AU 6 - 17906) **Fee:** $194.95 **Benefit:** 75% = $146.25 85% = $167.25
42803	PINGUECULA, removal of by laser in 1 or more stages (not for contact lenses) (AU 6 - 17906) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
42806	IRIS TUMOUR, laser photocoagulation of (AU 9 - 17909) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05

42809	RETINA, photocoagulation of (AU 9 - 17909) **Fee:** $321.35 **Benefit:** 75% = $241.05 85% = $293.65
42812	DETACHED RETINA, removal of encircling silicone band from (AU 8 - 17908) **Fee:** $117.85 **Benefit:** 75% = $88.40 85% = $100.20
42815	POSTERIOR CHAMBER, removal of silicone oil from (AU 12 - 17912) **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (AU 13 - 17913) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
42821	RETROBULBAR TRANSILLUMINATION, as an independent procedure (AU 5 - 17905) **Fee:** $64.25 **Benefit:** 75% = $48.20 85% = $54.65
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure **Fee:** $49.80 **Benefit:** 75% = $37.35 85% = $42.35
42827	BOTULINUS TOXIN, injection of, for blepharospasm, including all such injections on any 1 day (AU 5 - 17905) **Fee:** $32.15 **Benefit:** 75% = $24.15 85% = $27.35
42830	BOTULINUS TOXIN, injection of, for strabismus including all such injections on any 1 day and associated electromyography (AU 6 - 17906) **Fee:** $111.40 **Benefit:** 75% = $83.55 85% = $94.70
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES (AU 8 - 17908) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (AU 8 - 17908) **Fee:** $519.50 **Benefit:** 75% = $389.65 85% = $491.80
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES (AU 9 - 17909) **Fee:** $498.10 **Benefit:** 75% = $373.60 85% = $470.40
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (AU 9 - 17909) **Fee:** $621.30 **Benefit:** 75% = $466.00 85% = $593.60
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (AU 6 - 17906) *(See para T8.33 of explanatory notes to this Category)* **Fee:** $134.95 **Benefit:** 75% = $101.25 85% = $114.75
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) (AU 9 - 17909) **Fee:** $498.10 **Benefit:** 75% = $373.60 85% = $470.40
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) where there have been 2 or more previous squint operations on the eye or eyes (AU 9 - 17909) **Fee:** $621.30 **Benefit:** 75% = $466.00 85% = $593.60
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRA-OCULAR MUSCLE, repair of (AU 9 - 17909) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (AU 9 - 17909) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
42860	LID, upper or lower, scleral graft to, with recession of the lid retractors (AU 13 - 17913) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
42863	EYELID UPPER, recession of (AU 12 - 17912) **Fee:** $551.65 **Benefit:** 75% = $413.75 85% = $523.95

42866	ENTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation (AU 13 - 17913) **Fee:** $535.60 **Benefit:** 75% = $401.70 85% = $507.90
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (AU 11 - 17911) **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $363.30
42872	EYEBROW, elevation of, for paretic states (AU 9 - 17909) **Fee:** $171.40 **Benefit:** 75% = $128.55 85% = $145.70
	SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS
	OPERATIONS FOR ACUTE OSTEOMYELITIS
43500	OPERATION ON PHALANX (AU 7 - 17907) **Fee:** $87.85 **Benefit:** 75% = $65.90 85% = $74.70
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) - 1 BONE (AU 10 - 17910) **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95
43506	OPERATION ON HUMERUS OR FEMUR - 1 BONE (AU 10 - 17910) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
43509	OPERATION ON SPINE OR PELVIC BONES - 1 BONE (AU 13 - 17913) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
	OPERATIONS FOR CHRONIC OSTEOMYELITIS
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) - 1 BONE or ANY COMBINATION OF ADJOINING BONES (AU 12 - 17912) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
43515	OPERATION ON HUMERUS OR FEMUR - 1 BONE (AU 11 - 17911) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
43518	OPERATION ON SPINE OR PELVIC BONES - 1 BONE (AU 12 - 17912) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
43521	OPERATION ON SKULL (AU 12 - 17912) **Fee:** $330.75 **Benefit:** 75% = $248.10 85% = $303.05
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515, 43518 or 43521 (AU 12 - 17912) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
	SUBGROUP 11 - PAEDIATRIC
	OPERATIONS FOR CORRECTION OF CONGENITAL ABNORMALITIES
43800	HYPERTELORISM, correction of (AU 14 - 17914) **Fee:** $654.80 **Benefit:** 75% = $491.10 85% = $627.10
43803	CHOANAL ATRESIA, plastic repair of (AU 16 - 17916) **Fee:** $641.30 **Benefit:** 75% = $481.00 85% = $613.60
43806	CHOANAL ATRESIA, repair of by puncture and dilatation (AU 11 - 17911) **Fee:** $159.30 **Benefit:** 75% = $119.50 85% = $135.45

43809	MACROCHEILIA, MACROGLOSSIA OR MACROSTOMIA, operation for (AU 13 - 17913) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $316.55
43812	TORTICOLLIS, operation for (AU 7 - 17907) **Fee:** $261.90 **Benefit:** 75% = $196.45 85% = $234.20
43815	OESOPHAGUS, correction of congenital stenosis by oesophagectomy and anastomosis (AU 21 - 17921) **Fee:** $783.05 **Benefit:** 75% = $587.30 85% = $755.35
43818	TRACHEO-OESOPHAGEAL FISTULA (with or without atresia), ligation and division of (AU 20 - 17920) **Fee:** $783.05 **Benefit:** 75% = $587.30 85% = $755.35
43821	OESOPHAGEAL ATRESIA, with or without fistula, correction of (AU 23 - 17923) **Fee:** $972.05 **Benefit:** 75% = $729.05 85% = $944.35
43824	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, with or without resection, including reduction of volvulus (AU 15 - 17915) **Fee:** $681.80 **Benefit:** 75% = $511.35 85% = $654.10
43827	ANAL SPHINCTEROTOMY as an independent procedure for Hirschsprung's disease (AU 6 - 17906) **Fee:** $189.85 **Benefit:** 75% = $142.40 85% = $162.15
43830	RECTOSIGMOIDECTOMY for Hirschsprung's disease (AU 22 - 17922) **Fee:** $891.05 **Benefit:** 75% = $668.30 85% = $863.35
43833	EXOMPHALOS OR GASTROSCHISIS, operation for (AU 13 - 17913) **Fee:** $776.30 **Benefit:** 75% = $582.25 85% = $748.60
43836	EXOMPHALOS OR GASTROSCHISIS, operation for, by plastic flap (AU 14 - 17914) **Fee:** $864.05 **Benefit:** 75% = $648.05 85% = $836.35
43839	ANO-RECTAL MALFORMATION, perineal anoplasty, primary or secondary repair (AU 10 - 17910) **Fee:** $290.25 **Benefit:** 75% = $217.70 85% = $262.55
43842	ANO-RECTAL MALFORMATION, rectoplasty, primary or secondary repair, not being a service to which item 43839 applies (AU 18 - 17918) **Fee:** $843.80 **Benefit:** 75% = $632.85 85% = $816.10
43845	CONTRACTED BLADDER NECK (congenital), wedge excision or perurethral resection of (AU 11 - 17911) **Fee:** $432.00 **Benefit:** 75% = $324.00 85% = $404.30
43848	URACHAL FISTULA, operation for (AU 11 - 17911) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
43851	SPHINCTER RECONSTRUCTION for ectopia vesicae, ectopia cloacae or congenital incontinence (AU 12 - 17912) **Fee:** $857.30 **Benefit:** 75% = $643.00 85% = $829.60
43854	URETHRAL VALVES OR URETHRAL MEMBRANE, open removal of (AU 12 - 17912) **Fee:** $513.00 **Benefit:** 75% = $384.75 85% = $485.30
43857	LYMPHANGIECTASIS OF LIMB (Milroy's disease) - limited excision of (AU 14 - 17914) **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90
43860	LYMPHANGIECTASIS OF LIMB (Milroy's disease) - radical excision of (AU 18 - 17918) **Fee:** $587.30 **Benefit:** 75% = $440.50 85% = $559.60
	OPERATIONS FOR EXCISION OF CONGENITAL ABNORMALITIES
44100	EXTRA DIGIT, ligation of pedicle (AU 4 - 17904) **Fee:** $34.45 **Benefit:** 75% = $25.85 85% = $29.30
44103	EXTRA DIGIT, amputation of (AU 6 - 17906) **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60

44106 G 44107 S	DERMOID, periorbital or superficial nasal, excision of (AU 8 - 17908) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90 **Fee:** $162.00 **Benefit:** 75% = $121.50 85% = $137.70
44110	DERMOID, ORBITAL, excision of (AU 8 - 17908) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $316.55
44113	DERMOID OF NOSE, excision of, with intranasal extension (AU 8 - 17908) **Fee:** $405.00 **Benefit:** 75% = $303.75 85% = $377.30
	SUBGROUP 12 - AMPUTATIONS
44324 G 44325 S	HAND, MIDCARPAL OR TRANSMETACARPAL (AU 7 - 17907) **Fee:** $162.00 **Benefit:** 75% = $121.50 85% = $137.70 **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
44328	HAND, FOREARM OR THROUGH ARM (AU 8 - 17908) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
44331	AT SHOULDER (AU 12 - 17912) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
44334	INTERSCAPULOTHORACIC (AU 15 - 17915) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $822.85
44337 G 44338 S	1 DIGIT of foot (AU 6 - 17906) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15 **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25
44341 G 44342 S	2 DIGITS of 1 foot (AU 7 - 17907) **Fee:** $126.90 **Benefit:** 75% = $95.20 85% = $107.90 **Fee:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15
44345 G 44346 S	3 DIGITS of 1 foot (AU 8 - 17908) **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95 **Fee:** $180.90 **Benefit:** 75% = $135.70 85% = $153.80
44349 G 44350 S	4 DIGITS of 1 foot (AU 9 - 17909) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30 **Fee:** $205.20 **Benefit:** 75% = $153.90 85% = $177.50
44353 G 44354 S	5 DIGITS of 1 foot (AU 10 - 17910) **Fee:** $189.00 **Benefit:** 75% = $141.75 85% = $161.30 **Fee:** $234.90 **Benefit:** 75% = $176.20 85% = $207.20
44357 G 44358 S	TOE, including metatarsal or part of metatarsal - each toe (AU 7 - 17907) **Fee:** $102.60 **Benefit:** 75% = $76.95 85% = $87.25 **Fee:** $130.95 **Benefit:** 75% = $98.25 85% = $111.35
44361	FOOT AT ANKLE (Syme, Pirogoff types) (AU 8 - 17908) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL (AU 7 - 17907) **Fee:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
44367	THROUGH THIGH, AT KNEE OR BELOW KNEE (AU 10 - 17910) **Fee:** $371.70 **Benefit:** 75% = $278.80 85% = $344.00
44370	AT HIP (AU 14 - 17914) **Fee:** $513.00 **Benefit:** 75% = $384.75 85% = $485.30
44373	HINDQUARTER (AU 17 - 17917) **Fee:** $1,053.05 **Benefit:** 75% = $789.80 85% =$1,025.35

44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover **Derived Fee:** 75% of the original amputation fee
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
	METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR *(Note: See par. T8.36 of Explanatory notes to this Category for definition of "Local skin flap")* **GENERAL**
45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (AU 7 - 17907) **Fee:** $385.60 **Benefit:** 75% = $289.20 85% = $357.90
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (AU 11 - 17911) **Fee:** $428.45 **Benefit:** 75% = $321.35 85% = $400.75
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (AU 16 - 17916) **Fee:** $739.10 **Benefit:** 75% = $554.35 85% = $711.40
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (AU 11 - 17911) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $242.30
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (AU 17 - 17917) **Fee:** $452.25 **Benefit:** 75% = $339.20 85% = $424.55
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (AU 8 - 17908) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (AU 12 - 17912) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
45021	ABRASIVE THERAPY, limited to 1 aesthetic area (AU 6 - 17906) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $126.40 **Benefit:** 75% = $94.80 85% = $107.45
45024	ABRASIVE THERAPY to more than 1 aesthetic area (AU 7 - 17907) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $256.15
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 7 - 17907) **Fee:** $85.70 **Benefit:** 75% = $64.30 85% = $72.85
45030	ANGIOMA OF SKIN and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (AU 7 - 17907) **Fee:** $92.10 **Benefit:** 75% = $69.10 85% = $78.30
45033	ANGIOMA, large or involving deeper tissue including facial muscle or breast, excision and suture of (AU 9 - 17909) **Fee:** $171.40 **Benefit:** 75% = $128.55 85% = $145.70
45036	ANGIOMA OF NECK, deep, excision of (AU 10 - 17910) **Fee:** $803.40 **Benefit:** 75% = $602.55 85% = $775.70
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (AU 11 - 17911) **Fee:** $171.40 **Benefit:** 75% = $128.55 85% = $145.70

45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (AU 16 - 17916) **Fee:** $219.60 **Benefit:** 75% = $164.70 85% = $191.90
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (AU 16 - 17916) **Fee:** $219.60 **Benefit:** 75% = $164.70 85% = $191.90
45048	LYMPHOEDEMATOUS TISSUE of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (AU 15 - 17915) **Fee:** $551.65 **Benefit:** 75% = $413.75 85% = $523.95
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 T8.35 of explanatory notes to this Category)* **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $309.80
	SKIN FLAP SURGERY
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness (AU 7 - 17907) **Fee:** $202.50 **Benefit:** 75% = $151.90 85% = $174.80
45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness (AU 10 - 17910) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
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:** $273.15 **Benefit:** 75% = $204.90 85% = $245.45
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (AU 11 - 17911) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $309.80
45212	DIRECT FLAP REPAIR (cross arm, abdominal or similar), second stage (AU 9 - 17909) **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
45215	DIRECT FLAP REPAIR, cross leg, first stage (AU 13 - 17913) **Fee:** $722.30 **Benefit:** 75% = $541.75 85% = $694.60
45218	DIRECT FLAP REPAIR, cross leg, second stage (AU 10 - 17910) **Fee:** $324.00 **Benefit:** 75% = $243.00 85% = $296.30
45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (AU 7 - 17907) **Fee:** $186.30 **Benefit:** 75% = $139.75 85% = $158.60
45224	DIRECT FLAP REPAIR, small (cross finger or similar), second stage (AU 7 - 17907) **Fee:** $83.70 **Benefit:** 75% = $62.80 85% = $71.15
45227	INDIRECT FLAP OR TUBED PEDICLE, formation of (AU 10 - 17910) **Fee:** $317.25 **Benefit:** 75% = $237.95 85% = $289.55
45230	DIRECT OR INDIRECT FLAP OR TUBED PEDICLE, delay of (AU 8 - 17908) **Fee:** $158.55 **Benefit:** 75% = $118.95 85% = $134.80
45233	INDIRECT FLAP OR TUBED PEDICLE, preparation of intermediate or final site and attachment to the site (AU 10 - 17910) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $309.80
45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (AU 8 - 17908) **Fee:** $264.60 **Benefit:** 75% = $198.45 85% = $236.90
45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of (AU 7 - 17907) **Fee:** $186.30 **Benefit:** 75% = $139.75 85% = $158.60

	FREE GRAFTS
45400	FREE GRAFTING (split skin) of a granulating area, small (AU 7 - 17907) **Fee:** $145.80 **Benefit:** 75% = $109.35 85% = $123.95
45403	FREE GRAFTING (split skin) of a granulating area, extensive (AU 11 - 17911) **Fee:** $290.25 **Benefit:** 75% = $217.70 85% = $262.55
45406	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving not more than 3 per cent of total body surface (AU 8 - 17908) **Fee:** $321.35 **Benefit:** 75% = $241.05 85% = $293.65
45409	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 - 17910) **Fee:** $428.45 **Benefit:** 75% = $321.35 85% = $400.75
45412	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 - 17912) **Fee:** $589.15 **Benefit:** 75% = $441.90 85% = $561.45
45415	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 - 17914) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
45418	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 12 per cent or more of total body surface (AU 16 - 17916) **Fee:** $696.25 **Benefit:** 75% = $522.20 85% = $668.55
45421	FREE GRAFTING (split skin) to burns, including excision of burnt tissue, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (AU 18 - 17918) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
45424	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 - 17913) **Fee:** $235.65 **Benefit:** 75% = $176.75 85% = $207.95
45427	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 - 17915) **Fee:** $342.80 **Benefit:** 75% = $257.10 85% = $315.10
45430	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 - 17917) **Fee:** $503.45 **Benefit:** 75% = $377.60 85% = $475.75
45433	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 - 17919) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
45436	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 - 17921) **Fee:** $621.30 **Benefit:** 75% = $466.00 85% = $593.60
45439	FREE GRAFTING (split skin) to 1 defect, including elective dissection, small (AU 8 - 17908) **Fee:** $202.50 **Benefit:** 75% = $151.90 85% = $174.80
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (AU 11 - 17911) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (AU 11 - 17911) **Fee:** $396.35 **Benefit:** 75% = $297.30 85% = $368.65
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (AU 8 - 17908) **Fee:** $267.80 **Benefit:** 75% = $200.85 85% = $240.10

45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (AU 9 - 17909) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $309.80
	OTHER GRAFTS AND MISCELLANEOUS PROCEDURES
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (AU 14 - 17914) **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
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:** $1,264.00 **Benefit:** 75% = $948.00 85% =$1,236.30
45503	MICRO-ARTERIAL OR MICRO-VENOUS GRAFT using microsurgical techniques (AU 22 - 17922) **Fee:** $1,446.10 **Benefit:** 75% =$1,084.60 85% =$1,418.40
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:** $156.60 **Benefit:** 75% = $117.45 85% = $133.15
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:** $210.60 **Benefit:** 75% = $157.95 85% = $182.90
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:** $132.85 **Benefit:** 75% = $99.65 85% = $112.95
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:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
45521	MAMMAPLASTY, reduction (unilateral), with or without repositioning of nipple (AU 10 - 17910) **Fee:** $641.30 **Benefit:** 75% = $481.00 85% = $613.60
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (AU 10 - 17910) *(See para T8.37 of explanatory notes to this Category)* **Fee:** $528.20 **Benefit:** 75% = $396.15 85% = $500.50
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (AU 9 - 17909) **Fee:** $528.20 **Benefit:** 75% = $396.15 85% = $500.50
45530	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 - 17920) *(See para T8.38 of explanatory notes to this Category)* **Fee:** $782.50 **Benefit:** 75% = $586.90 85% = $754.80
45533	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 - 17915) **Fee:** $886.80 **Benefit:** 75% = $665.10 85% = $859.10
45536	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 - 17912) **Fee:** $326.05 **Benefit:** 75% = $244.55 85% = $298.35
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (AU 9 - 17909) **Fee:** $762.95 **Benefit:** 75% = $572.25 85% = $735.25

45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (AU 9 - 17909) **Fee:** $436.90 **Benefit:** 75% = $327.70 85% = $409.20
45545	NIPPLE OR AREOLA or both, reconstruction of by any technique (AU 10 - 17910) *(See para T8.39 of explanatory notes to this Category)* **Fee:** $443.40 **Benefit:** 75% = $332.55 85% = $415.70
45548	BREAST PROSTHESIS, removal of, as an independent procedure (AU 11 - 17911) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
45551	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule, as an independent procedure (AU 10 - 17910) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30
45552	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule and replacement of prosthesis (AU 13 - 17913) **Fee:** $454.90 **Benefit:** 75% = $341.20 85% = $427.20
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:** $498.10 **Benefit:** 75% = $373.60 85% = $470.40
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (AU 11 - 17911) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
45563	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 - 17915) **Fee:** $783.05 **Benefit:** 75% = $587.30 85% = $755.35
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (AU 10 - 17910) **Fee:** $762.95 **Benefit:** 75% = $572.25 85% = $735.25
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (AU 13 - 17913) **Fee:** $207.80 **Benefit:** 75% = $155.85 85% = $180.10
45575	FACIAL NERVE PARALYSIS, free fascia graft for (AU 12 - 17912) **Fee:** $513.00 **Benefit:** 75% = $384.75 85% = $485.30
45578	FACIAL NERVE PARALYSIS, muscle transfer for (AU 13 - 17913) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
45581	FACIAL NERVE PALSY, excision of tissue for (AU 12 - 17912) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (AU 13 - 17913) *(See para T8.40 of explanatory notes to this Category)* **Fee:** $449.90 **Benefit:** 75% = $337.45 85% = $422.20
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (AU 14 - 17914) *(See para T8.41 of explanatory notes to this Category)* **Fee:** $634.55 **Benefit:** 75% = $475.95 85% = $606.85
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (AU 12 - 17912) **Fee:** $344.25 **Benefit:** 75% = $258.20 85% = $316.55
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (AU 14 - 17914) **Fee:** $404.30 **Benefit:** 75% = $303.25 85% = $376.60
45596	MAXILLA, total resection of (AU 29 - 17929) **Fee:** $641.30 **Benefit:** 75% = $481.00 85% = $613.60

45597	MAXILLA, total resection of both maxillae (AU 30 - 17930) **Fee:** $858.45 **Benefit:** 75% = $643.85 85% = $830.75
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (AU 35 - 17935) **Fee:** $667.10 **Benefit:** 75% = $500.35 85% = $639.40
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (AU 19 - 17919) **Fee:** $498.10 **Benefit:** 75% = $373.60 85% = $470.40
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (AU 13 - 17913) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
45608	MANDIBLE, hemi-mandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (AU 15 - 17915) **Fee:** $587.30 **Benefit:** 75% = $440.50 85% = $559.60
45611	MANDIBLE, condylectomy (AU 11 - 17911) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $309.80
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (AU 10 - 17910) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
45617	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 1 of these conditions, the restoration of symmetry of the contralateral upper eyelid (AU 7 - 17907) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $167.40 **Benefit:** 75% = $125.55 85% = $142.30
45620	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (AU 8 - 17908) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
45623	PTOSIS of eyelid (unilateral), correction of (AU 12 - 17912) **Fee:** $553.50 **Benefit:** 75% = $415.15 85% = $525.80
45626	ECTROPION OR ENTROPION, correction of (unilateral) (AU 9 - 17909) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
45629	SYMBLEPHARON, grafting for (AU 8 - 17908) **Fee:** $337.50 **Benefit:** 75% = $253.15 85% = $309.80
45632	RHINOPLASTY, correction of lateral or alar cartilages (AU 10 - 17910) **Fee:** $364.50 **Benefit:** 75% = $273.40 85% = $336.80
45635	RHINOPLASTY, correction of bony vault only (AU 10 - 17910) **Fee:** $418.50 **Benefit:** 75% = $313.90 85% = $390.80
45638	RHINOPLASTY - TOTAL, including correction of all bony and cartilaginous elements of the external nose (AU 12 - 17912) **Fee:** $722.30 **Benefit:** 75% = $541.75 85% = $694.60
45641	RHINOPLASTY involving nasal or septal cartilage graft (AU 14 - 17914) **Fee:** $771.25 **Benefit:** 75% = $578.45 85% = $743.55
45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (AU 13 - 17913) **Fee:** $911.30 **Benefit:** 75% = $683.50 85% = $883.60
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (AU 18 - 17918) **Fee:** $910.50 **Benefit:** 75% = $682.90 85% = $882.80
45650	RHINOPLASTY, secondary revision of (AU 10 - 17910) **Fee:** $105.30 **Benefit:** 75% = $79.00 85% = $89.55

45653	RHINOPHYMA, shaving of (AU 9 - 17909) **Fee:** $253.80 **Benefit:** 75% = $190.35 85% = $226.10
45656	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (AU 11 - 17911) **Fee:** $357.75 **Benefit:** 75% = $268.35 85% = $330.05
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (AU 8 - 17908) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (AU 11 - 17911) **Fee:** $499.50 **Benefit:** 75% = $374.65 85% = $471.80
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (AU 8 - 17908) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
45668	VERMILIONECTOMY (AU 8 - 17908) **Fee:** $232.20 **Benefit:** 75% = $174.15 85% = $204.50
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (AU 11 - 17911) **Fee:** $594.05 **Benefit:** 75% = $445.55 85% = $566.35
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (AU 4 - 17904) **Fee:** $172.80 **Benefit:** 75% = $129.60 85% = $146.90
45677	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (AU 12 - 17912) **Fee:** $385.60 **Benefit:** 75% = $289.20 85% = $357.90
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (AU 14 - 17914) **Fee:** $482.05 **Benefit:** 75% = $361.55 85% = $454.35
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (AU 14 - 17914) **Fee:** $535.60 **Benefit:** 75% = $401.70 85% = $507.90
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (AU 16 - 17916) **Fee:** $632.00 **Benefit:** 75% = $474.00 85% = $604.30
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (AU 10 - 17910) **Fee:** $186.40 **Benefit:** 75% = $139.80 85% = $158.70
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (AU 10 - 17910) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (AU 12 - 17912) **Fee:** $348.15 **Benefit:** 75% = $261.15 85% = $320.45
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (AU 10 - 17910) **Fee:** $326.70 **Benefit:** 75% = $245.05 85% = $299.00
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (AU 12 - 17912) **Fee:** $589.15 **Benefit:** 75% = $441.90 85% = $561.45
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (AU 8 - 17908) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $186.55
45707	CLEFT PALATE, primary repair (AU 14 - 17914) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (AU 13 - 17913) **Fee:** $348.15 **Benefit:** 75% = $261.15 85% = $320.45
45713	CLEFT PALATE, secondary repair, lengthening procedure (AU 12 - 17912) **Fee:** $396.35 **Benefit:** 75% = $297.30 85% = $368.65

45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (AU 15 - 17915) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
45719	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 - 17916) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $776.60 **Benefit:** 75% = $582.45 85% = $748.90
45722	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 - 17920) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $985.50 **Benefit:** 75% = $739.15 85% = $957.80
45725	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (AU 14 - 17914) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $688.55 **Benefit:** 75% = $516.45 85% = $660.85
45728	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (AU 18 - 17918) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $877.55 **Benefit:** 75% = $658.20 85% = $849.85
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (AU 22 - 17922) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $999.05 **Benefit:** 75% = $749.30 85% = $971.35
45734	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (AU 26 - 17926) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,147.55 **Benefit:** 75% = $860.70 85% =$1,119.85
45737	MANDIBLE OR MAXILLA, complex bilateral osteotomies or osteectomies of involving 3 or more such procedures of 1 jaw and 2 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 - 17932) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,262.30 **Benefit:** 75% = $946.75 85% =$1,234.60
45740	MANDIBLE or MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 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 - 17934) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,377.05 **Benefit:** 75% =$1,032.80 85% =$1,349.35
45743	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 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 - 17924) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,124.75 **Benefit:** 75% = $843.60 85% =$1,097.05
45746	MANDIBLE OR MAXILLA, osteotomies or oteectomies of, involving 2 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 - 17928) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,290.75 **Benefit:** 75% = $968.10 85% =$1,263.05
45749	MANDIBLE OR MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 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 - 17934) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,419.30 **Benefit:** 75% =$1,064.50 85% =$1,391.60

45752	MANDIBLE OR MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 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 - 17936) *(See para T8.43 of explanatory notes to this Category)* **Fee:** $1,542.50 **Benefit:** 75% =$1,156.90 85% =$1,514.80
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:** $1,551.75 **Benefit:** 75% =$1,163.85 85% =$1,524.05
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:** $1,860.05 **Benefit:** 75% =$1,395.05 85% =$1,832.35
45755	TEMPORO-MANDIBULAR MENISCECTOMY (AU 9 - 17909) **Fee:** $261.90 **Benefit:** 75% = $196.45 85% = $234.20
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (AU 6 - 17906) **Fee:** $468.70 **Benefit:** 75% = $351.55 85% = $441.00
45761	GENIOPLASTY, including transposition of nerves and bone grafts taken from the same site (AU 10 - 17910) *(See para T8.44 of explanatory notes to this Category)* **Fee:** $533.25 **Benefit:** 75% = $399.95 85% = $505.55
45764	GENIOPLASTY being a service associated with a service to which item 45719, 45722, 45725, 45728, 45731, 45734, 45743 or 45746 applies (AU 8 - 17908) *(See para T8.44 of explanatory notes to this Category)* **Fee:** $310.50 **Benefit:** 75% = $232.90 85% = $282.80
45767	HYPERTELORISM, correction of, intra-cranial (AU 47 - 17947) **Fee:** $1,788.85 **Benefit:** 75% =$1,341.65 85% =$1,761.15
45770	HYPERTELORISM, correction of, sub-cranial (AU 26 - 17926) **Fee:** $1,370.30 **Benefit:** 75% =$1,027.75 85% =$1,342.60
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (AU 30 - 17930) **Fee:** $1,248.80 **Benefit:** 75% = $936.60 85% =$1,221.10
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intra-cranial (AU 35 - 17935) **Fee:** $1,248.80 **Benefit:** 75% = $936.60 85% =$1,221.10
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extra-cranial (AU 18 - 17918) **Fee:** $918.05 **Benefit:** 75% = $688.55 85% = $890.35
45782	FRONTO-ORBITAL ADVANCEMENT, UNILATERAL (AU 19 - 17919) **Fee:** $702.05 **Benefit:** 75% = $526.55 85% = $674.35
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition - (bilateral fronto-orbital advancement) (AU 39 - 17939) **Fee:** $1,188.05 **Benefit:** 75% = $891.05 85% =$1,160.35
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (AU 19 - 17919) **Fee:** $1,174.55 **Benefit:** 75% = $880.95 85% =$1,146.85
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (AU 15 - 17915) **Fee:** $634.55 **Benefit:** 75% = $475.95 85% = $606.85
45794	OSSEO-INTEGRATION PROCEDURE - extra oral, implantation of titanium fixture (AU 20 - 17920) **Fee:** $358.85 **Benefit:** 75% = $269.15 85% = $331.15

45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment (AU 16 - 17916) **Fee:** $132.85 **Benefit:** 75% = $99.65 85% = $112.95
	SUBGROUP 14 - HAND SURGERY
	Note: Items 46300 to 46510 are restricted to surgery on the hand/s.
46300	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of (AU 9 - 17909) **Fee:** $241.05 **Benefit:** 75% = $180.80 85% = $213.35
46303	CARPOMETACARPAL JOINT, arthrodesis of (AU 10 - 17910) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $240.15
46306	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of (including volar plate arthroplasty), and including tendon transfers or realignment on the 1 ray (AU 10 - 17910) **Fee:** $375.00 **Benefit:** 75% = $281.25 85% = $347.30
46309	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (AU 10 - 17910) **Fee:** $375.00 **Benefit:** 75% = $281.25 85% = $347.30
46312	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (AU 11 - 17911) **Fee:** $482.15 **Benefit:** 75% = $361.65 85% = $454.45
46315	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (AU 14 - 17914) **Fee:** $642.85 **Benefit:** 75% = $482.15 85% = $615.15
46318	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (AU 15 - 17915) **Fee:** $803.55 **Benefit:** 75% = $602.70 85% = $775.85
46321	INTER-PHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (AU 16 - 17916) **Fee:** $964.30 **Benefit:** 75% = $723.25 85% = $936.60
46324	CARPAL BONE replacement arthroplasty including associated tendon transfer or realignment when performed (AU 15 - 17915) **Fee:** $541.05 **Benefit:** 75% = $405.80 85% = $513.35
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (AU 8 - 17908) **Fee:** $144.65 **Benefit:** 75% = $108.50 85% = $123.00
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of, with ligamentous or capsular repair (AU 9 - 17909) **Fee:** $246.45 **Benefit:** 75% = $184.85 85% = $218.75
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (AU 10 - 17910) **Fee:** $401.80 **Benefit:** 75% = $301.35 85% = $374.10
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (AU 9 - 17909) **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.80
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (AU 10 - 17910) **Fee:** $332.15 **Benefit:** 75% = $249.15 85% = $304.45
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (AU 10 - 17910) **Fee:** $332.15 **Benefit:** 75% = $249.15 85% = $304.45

46345	RECONSTRUCTION of DISTAL RADIOULNAR JOINT (AU 11 - 17911) **Fee:** $401.80 **Benefit:** 75% = $301.35 85% = $374.10
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (AU 9 - 17909) **Fee:** $174.10 **Benefit:** 75% = $130.60 85% = $148.00
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (AU 11 - 17911) **Fee:** $259.80 **Benefit:** 75% = $194.85 85% = $232.10
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (AU 12 - 17912) **Fee:** $348.20 **Benefit:** 75% = $261.15 85% = $320.50
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (AU 14 - 17914) **Fee:** $433.95 **Benefit:** 75% = $325.50 85% = $406.25
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (AU 15 - 17915) **Fee:** $522.30 **Benefit:** 75% = $391.75 85% = $494.60
46363	TENDON SHEATH of hand or wrist, open operation on, for STENOSING TENDOVAGINITIS (AU 7 - 17907) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - 1 hand (AU 7 - 17907) **Fee:** $91.05 **Benefit:** 75% = $68.30 85% = $77.40
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (AU 9 - 17909) **Fee:** $91.05 **Benefit:** 75% = $68.30 85% = $77.40
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (AU 10 - 17910) **Fee:** $304.80 **Benefit:** 75% = $228.60 85% = $277.10
46375	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - 1 hand (AU 11 - 17911) **Fee:** $361.60 **Benefit:** 75% = $271.20 85% = $333.90
46378	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - 1 hand (AU 14 - 17914) **Fee:** $482.15 **Benefit:** 75% = $361.65 85% = $454.45
46381	INTER-PHALANGEAL JOINT, joint capsule release when performed in conjunction with operation for Dupuytren's Contracture - each procedure (AU 7 - 17907) **Fee:** $214.30 **Benefit:** 75% = $160.75 85% = $186.60
46384	Z-PLASTY (or similar local flap procedure) when performed in conjunction with operation for Dupuytren's Contracture - 1 such procedure (AU 7 - 17907) **Fee:** $214.30 **Benefit:** 75% = $160.75 85% = $186.60
46387	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - operation for recurrence in that ray (AU 11 - 17911) **Fee:** $441.95 **Benefit:** 75% = $331.50 85% = $414.25
46390	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 2 rays, including dissection of nerves - operation for recurrence in those rays (AU 15 - 17915) **Fee:** $589.30 **Benefit:** 75% = $442.00 85% = $561.60
46393	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 3 or more rays, including dissection of nerves - operation for recurrence in those rays (AU 17 - 17917) **Fee:** $683.05 **Benefit:** 75% = $512.30 85% = $655.35
46396	PHALANX or METACARPAL of the hand, osteotomy or osteectomy of (AU 9 - 17909) **Fee:** $241.05 **Benefit:** 75% = $180.80 85% = $213.35
46399	PHALANX or METACARPAL of the hand, osteotomy of, with internal fixation (AU 11 - 17911) **Fee:** $294.65 **Benefit:** 75% = $221.00 85% = $266.95

46402	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), including obtaining of graft material (AU 12 - 17912) **Fee:** $294.65 **Benefit:** 75% = $221.00 85% = $266.95
46405	PHALANX or METACARPAL, bone grafting of, for pseudarthrosis (non-union), involving internal fixation and including obtaining of graft material (AU 13 - 17913) **Fee:** $401.80 **Benefit:** 75% = $301.35 85% = $374.10
46408	TENDON, reconstruction of, by tendon graft (AU 14 - 17914) **Fee:** $492.85 **Benefit:** 75% = $369.65 85% = $465.15
46411	FLEXOR TENDON PULLEY, reconstruction of, by graft (AU 10 - 17910) **Fee:** $289.30 **Benefit:** 75% = $217.00 85% = $261.60
46414	ARTIFICIAL TENDON PROSTHESIS, INSERTION OF, in preparation for tendon grafting (AU 11 - 17911) **Fee:** $374.90 **Benefit:** 75% = $281.20 85% = $347.20
46417	TENDON transfer for restoration of hand function, each transfer (AU 11 - 17911) **Fee:** $348.20 **Benefit:** 75% = $261.15 85% = $320.50
46420	EXTENSOR TENDON OF HAND OR WRIST, primary repair of, each tendon (AU 10 - 17910) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
46423	EXTENSOR TENDON OF HAND OR WRIST, secondary repair of, each tendon (AU 10 - 17910) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $205.35
46426	FLEXOR TENDON OF HAND OR WRIST, primary repair of, proximal to A1 pulley, each tendon (AU 10 - 17910) **Fee:** $241.05 **Benefit:** 75% = $180.80 85% = $213.35
46429	FLEXOR TENDON OF HAND OR WRIST, secondary repair of, proximal to A1 pulley, each tendon (AU 11 - 17911) **Fee:** $294.65 **Benefit:** 75% = $221.00 85% = $266.95
46432	FLEXOR TENDON OF HAND, primary repair of, distal to A1 pulley, each tendon (AU 11 - 17911) **Fee:** $321.45 **Benefit:** 75% = $241.10 85% = $293.75
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (AU 12 - 17912) **Fee:** $375.00 **Benefit:** 75% = $281.25 85% = $347.30
46438	MALLET FINGER, closed pin fixation of (AU 7 - 17907) **Fee:** $96.45 **Benefit:** 75% = $72.35 85% = $82.00
46441	MALLET FINGER, open repair of, including pin fixation when performed (AU 9 - 17909) **Fee:** $233.05 **Benefit:** 75% = $174.80 85% = $205.35
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (AU 10 - 17910) **Fee:** $348.20 **Benefit:** 75% = $261.15 85% = $320.50
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (AU 12 - 17912) **Fee:** $433.95 **Benefit:** 75% = $325.50 85% = $406.25
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (AU 8 - 17908) **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (AU 9 - 17909) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $240.15
46456	FINGER, percutaneous tenotomy of (AU 7 - 17907) **Fee:** $69.65 **Benefit:** 75% = $52.25 85% = $59.25
46459	OPERATION for OSTEOMYELITIS on distal phalanx (AU 9 - 17909) **Fee:** $133.95 **Benefit:** 75% = $100.50 85% = $113.90
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (AU 10 - 17910) **Fee:** $214.30 **Benefit:** 75% = $160.75 85% = $186.60

46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (AU 8 - 17908) **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (AU 10 - 17910) **Fee:** $281.25 **Benefit:** 75% = $210.95 85% = $253.55
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (AU 13 - 17913) **Fee:** $401.80 **Benefit:** 75% = $301.35 85% = $374.10
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (AU 15 - 17915) **Fee:** $522.30 **Benefit:** 75% = $391.75 85% = $494.60
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (AU 16 - 17916) **Fee:** $642.85 **Benefit:** 75% = $482.15 85% = $615.15
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone and requiring soft tissue cover, including metacarpal (AU 10 - 17910) **Fee:** $267.85 **Benefit:** 75% = $200.90 85% = $240.15
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (AU 9 - 17909) **Fee:** $214.30 **Benefit:** 75% = $160.75 85% = $186.60
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 8 - 17908) **Fee:** $160.70 **Benefit:** 75% = $120.55 85% = $136.60
46489	NAIL BED, secondary exploration and accurate repair of nail bed deformity using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 9 - 17909) **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.80
46492	FLEXION CONTRACTURE of HAND OR DIGIT, correction of, involving tissues deeper than skin and subcutaneous tissue (AU 9 - 17909) **Fee:** $241.05 **Benefit:** 75% = $180.80 85% = $213.35
46495	GANGLION OR MUCOUS CYST OF DISTAL DIGIT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (AU 9 - 17909) **Fee:** $144.65 **Benefit:** 75% = $108.50 85% = $123.00
46498	GANGLION OF FLEXOR TENDON SHEATH, excision of, not being a service associated with a service to which item 30106 or 30107 applies (AU 9 - 17909) **Fee:** $128.55 **Benefit:** 75% = $96.45 85% = $109.30
46501	GANGLION OF VOLAR OR DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (AU 10 - 17910) **Fee:** $187.50 **Benefit:** 75% = $140.65 85% = $159.80
46504	NEUROVASCULAR ISLAND FLAP, for pulp innervation (AU 19 - 17919) **Fee:** $787.50 **Benefit:** 75% = $590.65 85% = $759.80
46507	DIGIT, transposition of - complete procedure (AU 23 - 17923) **Fee:** $916.05 **Benefit:** 75% = $687.05 85% = $888.35
46510	MACRODACTYLY, surgical reduction of enlarged elements - each digit (AU 14 - 17914) **Fee:** $188.55 **Benefit:** 75% = $141.45 85% = $160.85

	SUBGROUP 15 - ORTHOPAEDIC
	TREATMENT OF DISLOCATIONS *(Note: See paragraph T8.45 of explanatory notes to this Category)*
47000	MANDIBLE, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $50.30 **Benefit:** 75% = $37.75 85% = $42.80
47003	CLAVICLE, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
47006	CLAVICLE, treatment of dislocation of, by open reduction (AU 9 - 17909) **Fee:** $121.30 **Benefit:** 75% = $91.00 85% = $103.15
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (AU 6 - 17906) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (AU 9 - 17909) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $213.70
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
47018	ELBOW, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
47021	ELBOW, treatment of dislocation of, by open reduction (AU 9 - 17909) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (AU 6 - 17906) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (AU 9 - 17909) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (AU 10 - 17910) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (AU 8 - 17908) **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (AU 8 - 17908) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (AU 9 - 17909) **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
47048	HIP, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $231.35 **Benefit:** 75% = $173.55 85% = $203.65
47051	HIP, treatment of dislocation of, by open reduction (AU 11 - 17911) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75

47054	KNEE, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $231.35 **Benefit:** 75% = $173.55 85% = $203.65
47057	PATELLA, treatment of dislocation of, by closed reduction (AU 6 - 17906) **Fee:** $90.50 **Benefit:** 75% = $67.90 85% = $76.95
47060	PATELLA, treatment of dislocation of, by open reduction (AU 10 - 17910) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (AU 8 - 17908) **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (AU 12 - 17912) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $213.70
47069	TOE, treatment of dislocation of, by closed reduction (AU 5 - 17905) **Fee:** $50.30 **Benefit:** 75% = $37.75 85% = $42.80
47072	TOE, treatment of dislocation of, by open reduction (AU 7 - 17907) **Fee:** $67.05 **Benefit:** 75% = $50.30 85% = $57.00
	TREATMENT OF FRACTURES *(Note: See paragraph T8.45 of explanatory notes to this Category)*
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (AU 6 - 17906) **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (AU 6 - 17906) **Fee:** $70.40 **Benefit:** 75% = $52.80 85% = $59.85
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (AU 8 - 17908) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (AU 8 - 17908) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (AU 6 - 17906) **Fee:** $90.50 **Benefit:** 75% = $67.90 85% = $76.95
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (AU 6 - 17906) **Fee:** $103.95 **Benefit:** 75% = $78.00 85% = $88.40
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (AU 8 - 17908) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (AU 8 - 17908) **Fee:** $150.85 **Benefit:** 75% = $113.15 85% = $128.25
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (AU 6 - 17906) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (AU 6 - 17906) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (AU 8 - 17908) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (AU 8 - 17908) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
47336	METACARPAL, treatment of fracture of, by closed reduction (AU 6 - 17906) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60

47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (AU 6 - 17906) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
47342	METACARPAL, treatment of fracture of, by open reduction (AU 10 - 17910) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (AU 10 - 17910) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (AU 6 - 17906) **Fee:** $67.05 **Benefit:** 75% = $50.30 85% = $57.00
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (AU 11 - 17911) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (AU 6 - 17906) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (AU 12 - 17912) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
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:** $93.90 **Benefit:** 75% = $70.45 85% = $79.85
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (AU 6 - 17906) **Fee:** $140.80 **Benefit:** 75% = $105.60 85% = $119.70
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (AU 11 - 17911) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
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:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (AU 6 - 17906) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (AU 11 - 17911) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
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:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day hospital facility (AU 7 - 17907) **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (AU 11 - 17911) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $213.70
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital or approved day hospital facility (AU 11 - 17911) **Fee:** $207.85 **Benefit:** 75% = $155.90 85% = $180.15
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (AU 12 - 17912) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
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:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75

47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day hospital facility (AU 7 - 17907) **Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $264.00
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (AU 11 - 17911) **Fee:** $388.90 **Benefit:** 75% = $291.70 85% = $361.20
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (AU 7 - 17907) **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
47399	OLECRANON, treatment of fracture of, by open reduction (AU 12 - 17912) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (AU 11 - 17911) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
47405	RADIUS, treatment of fracture of head or neck of, closed management of (AU 6 - 17906) **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
47408	RADIUS, treatment of fracture of head or neck of, open management of, including internal fixation and excision where performed (AU 12 - 17912) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (AU 6 - 17906) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (AU 11 - 17911) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (AU 8 - 17908) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (AU 15 - 17915) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $341.10
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (AU 8 - 17908) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day hospital facility (AU 8 - 17908) **Fee:** $231.35 **Benefit:** 75% = $173.55 85% = $203.65
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (AU 15 - 17915) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (AU 17 - 17917) **Fee:** $385.55 **Benefit:** 75% = $289.20 85% = $357.85
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (AU 9 - 17909) **Fee:** $295.05 **Benefit:** 75% = $221.30 85% = $267.35
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (AU 17 - 17917) **Fee:** $469.40 **Benefit:** 75% = $352.05 85% = $441.70
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (AU 17 - 17917) **Fee:** $586.70 **Benefit:** 75% = $440.05 85% = $559.00
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (AU 8 - 17908) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85

47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day hospital facility (AU 9 - 17909) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $213.70
47450	HUMERUS, shaft of, treatment of fracture of, by open reduction (AU 15 - 17915) **Fee:** $321.85 **Benefit:** 75% = $241.40 85% = $294.15
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (AU 8 - 17908) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day hospital facility (AU 8 - 17908) **Fee:** $281.65 **Benefit:** 75% = $211.25 85% = $253.95
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital or approved day hospital facility (AU 15 - 17915) **Fee:** $375.50 **Benefit:** 75% = $281.65 85% = $347.80
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (AU 7 - 17907) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47465	CLAVICLE, treatment of fracture of, by open reduction (AU 13 - 17913) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (AU 7 - 17907) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47467	STERNUM, treatment of fracture of, by open reduction (AU 13 - 17913) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (AU 15 - 17915) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
47471	RIBS (1 or more), treatment of fracture of - each attendance **Fee:** $30.55 **Benefit:** 75% = $22.95 85% = $26.00
47474	PELVIC RING, treatment of fracture of, not involving disrupting pelvic ring or acetabulum **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
47477	PELVIC RING, treatment of fracture of, with disrupting pelvic ring or acetabulum **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47480	PELVIC RING, treatment of fracture of, requiring traction (AU 7 - 17907) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (AU 12 - 17912) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (AU 20 - 17920) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (AU 24 - 17924) **Fee:** $1,005.80 **Benefit:** 75% = $754.35 85% = $978.10
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (AU 7 - 17907) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (AU 8 - 17908) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55

47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (AU 16 - 17916) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (AU 20 - 17920) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (AU 24 - 17924) **Fee:** $1,005.80 **Benefit:** 75% = $754.35 85% = $978.10
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (AU 24 - 17924) **Fee:** $1,005.80 **Benefit:** 75% = $754.35 85% = $978.10
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (AU 24 - 17924) **Fee:** $1,005.80 **Benefit:** 75% = $754.35 85% = $978.10
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (AU 18 - 17918) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47516	FEMUR, treatment of fracture of, by closed reduction or traction (AU 8 - 17908) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (AU 14 - 17914) **Fee:** $616.90 **Benefit:** 75% = $462.70 85% = $589.20
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (AU 13 - 17913) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (AU 13 - 17913) **Fee:** $616.90 **Benefit:** 75% = $462.70 85% = $589.20
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (AU 14 - 17914) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
47531	FEMUR, treatment of fracture of shaft, by internal fixation and cross fixation (AU 15 - 17915) **Fee:** $683.95 **Benefit:** 75% = $513.00 85% = $656.25
47534	FEMUR, condylar region of, treatment of intra-articular (T shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (AU 20 - 17920) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (AU 14 - 17914) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (AU 9 - 17909) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (AU 8 - 17908) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (AU 8 - 17908) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $213.70
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (AU 13 - 17913) **Fee:** $321.85 **Benefit:** 75% = $241.40 85% = $294.15

47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (AU 12 - 17912) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (AU 8 - 17908) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (AU 13 - 17913) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
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:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (AU 8 - 17908) **Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $264.00
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (AU 8 - 17908) **Fee:** $338.60 **Benefit:** 75% = $253.95 85% = $310.90
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (AU 12 - 17912) **Fee:** $388.90 **Benefit:** 75% = $291.70 85% = $361.20
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (AU 15 - 17915) **Fee:** $486.15 **Benefit:** 75% = $364.65 85% = $458.45
47576	FIBULA, treatment of fracture of (AU 6 - 17906) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (AU 6 - 17906) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (AU 10 - 17910) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
47585	PATELLA, treatment of fracture of, by internal fixation (AU 12 - 17912) **Fee:** $301.75 **Benefit:** 75% = $226.35 85% = $274.05
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (AU 19 - 17919) **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
47591	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (AU 23 - 17923) **Fee:** $1,139.90 **Benefit:** 75% = $854.95 85% =$1,112.20
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (AU 8 - 17908) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (AU 8 - 17908) **Fee:** $231.35 **Benefit:** 75% = $173.55 85% = $203.65
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (AU 10 - 17910) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (AU 12 - 17912) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (AU 8 - 17908) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55

47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (AU 9 - 17909) **Fee:** $251.45 **Benefit:** 75% = $188.60 85% = $223.75
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (AU 9 - 17909) **Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $264.00
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (AU 12 - 17912) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (AU 13 - 17913) **Fee:** $419.10 **Benefit:** 75% = $314.35 85% = $391.40
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (AU 9 - 17909) **Fee:** $291.70 **Benefit:** 75% = $218.80 85% = $264.00
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (AU 14 - 17914) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (AU 8 - 17908) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (AU 13 - 17913) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $213.70
47633	METATARSAL, 1 of, treatment of fracture of (AU 6 - 17906) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (AU 6 - 17906) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (AU 8 - 17908) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47642	METATARSALS, 2 of, treatment of fracture of (AU 7 - 17907) **Fee:** $107.30 **Benefit:** 75% = $80.50 85% = $91.25
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (AU 7 - 17907) **Fee:** $160.95 **Benefit:** 75% = $120.75 85% = $136.85
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (AU 11 - 17911) **Fee:** $214.55 **Benefit:** 75% = $160.95 85% = $186.85
47651	METATARSALS, 3 or more of, treatment of fracture of (AU 8 - 17908) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (AU 8 - 17908) **Fee:** $251.45 **Benefit:** 75% = $188.60 85% = $223.75
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (AU 10 - 17910) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (AU 7 - 17907) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (AU 9 - 17909) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (AU 8 - 17908) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40

47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (AU 11 - 17911) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance **Fee:** $30.55 **Benefit:** 75% = $22.95 85% = $26.00
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, including immobilisation by calipers (AU 9 - 17909) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, including immobilisation by calipers, and including up to 14 days post-operative care **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation (AU 9 - 17909) **Fee:** $737.60 **Benefit:** 75% = $553.20 85% = $709.90
47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation, including up to 14 days post-operative care **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 9 - 17909) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (AU 18 - 17918) **Fee:** $1,072.85 **Benefit:** 75% = $804.65 85% =$1,045.15
47702	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (AU 18 - 17918) **Fee:** $1,341.10 **Benefit:** 75% =$1,005.85 85% =$1,313.40
47703	SKULL, treatment of fracture of, each attendance **Fee:** $30.55 **Benefit:** 75% = $22.95 85% = $26.00
47705	SKULL CALIPERS, insertion of, as an independent procedure (AU 8 - 17908) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
47708	PLASTER JACKET, application of, as an independent procedure (AU 8 - 17908) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10
47711	HALO, application of, as an independent procedure (AU 8 - 17908) **Fee:** $228.00 **Benefit:** 75% = $171.00 85% = $200.30
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (AU 8 - 17908) **Fee:** $171.00 **Benefit:** 75% = $128.25 85% = $145.35
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (AU 11 - 17911) **Fee:** $301.75 **Benefit:** 75% = $226.35 85% = $274.05
47720	HALO-FEMORAL TRACTION, as an independent procedure (AU 10 - 17910) **Fee:** $301.75 **Benefit:** 75% = $226.35 85% = $274.05
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (AU 12 - 17912) **Fee:** $301.75 **Benefit:** 75% = $226.35 85% = $274.05
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (AU 7 - 17907) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55

47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (AU 7 - 17907) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (AU 8 - 17908) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies **Fee:** $30.55 **Benefit:** 75% = $22.95 85% = $26.00
47738	NASAL BONES, treatment of fracture of, by reduction (AU 8 - 17908) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (AU 12 - 17912) **Fee:** $342.00 **Benefit:** 75% = $256.50 85% = $314.30
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (AU 14 - 17914) **Fee:** $289.60 **Benefit:** 75% = $217.20 85% = $261.90
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (AU 14 - 17914) **Fee:** $289.60 **Benefit:** 75% = $217.20 85% = $261.90
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (AU 7 - 17907) **Fee:** $169.60 **Benefit:** 75% = $127.20 85% = $144.20
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (AU 9 - 17909) **Fee:** $279.25 **Benefit:** 75% = $209.45 85% = $251.55
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal and/or external fixation at 2 sites (AU 10 - 17910) **Fee:** $341.30 **Benefit:** 75% = $256.00 85% = $313.60
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal and/or external fixation at 3 sites (AU 11 - 17911) **Fee:** $393.00 **Benefit:** 75% = $294.75 85% = $365.30
47774	MAXILLA, treatment of fracture of, requiring open operation (AU 7 - 17907) **Fee:** $310.30 **Benefit:** 75% = $232.75 85% = $282.60
47777	MANDIBLE, treatment of fracture of, requiring open reduction (AU 7 - 17907) **Fee:** $310.30 **Benefit:** 75% = $232.75 85% = $282.60
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (AU 9 - 17909) **Fee:** $403.35 **Benefit:** 75% = $302.55 85% = $375.65
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (AU 9 - 17909) **Fee:** $403.35 **Benefit:** 75% = $302.55 85% = $375.65
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (AU 11 - 17911) **Fee:** $511.95 **Benefit:** 75% = $384.00 85% = $484.25
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (AU 11 - 17911) **Fee:** $511.95 **Benefit:** 75% = $384.00 85% = $484.25
	GENERAL
47900	BONE CYST, injection into or aspiration of (AU 8 - 17908) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47903	EPICONDYLITIS, open operation for (AU 8 - 17908) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55

47904	DIGITAL NAIL, removal of, not being a service to which item 47906 applies (AU 5 - 17905) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
47906	DIGITAL NAIL, removal of, in the operating theatre of a hospital or approved day hospital facility (AU 5 - 17905) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47909	MIDDLE PALMAR, THENAR OR HYPOTHENAR SPACES, drainage of (excluding aftercare) (AU 6 - 17906) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55
47912	PULP SPACE INFECTION, PARONYCHIA of HANDS or FEET, incision for, not being a service to which another item in this Group applies (excluding after-care) (AU 5 - 17905) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
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:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
47916	INGROWING nail of finger or toe, partial resection of nail, including phenolisation but not including excision of nail bed (AU 5 - 17905) **Fee:** $60.65 **Benefit:** 75% = $45.50 85% = $51.60
47918	INGROWING TOENAIL, radical excision of nailbed (AU 6 - 17906) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (AU 6 - 17906) **Fee:** $80.45 **Benefit:** 75% = $60.35 85% = $68.40
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (AU 6 - 17906) **Fee:** $26.80 **Benefit:** 75% = $20.10 85% = $22.80
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day hospital facility - per bone (AU 6 - 17906) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, removal of, not being a service associated with a service to which item 47924 or 47927 applies - per bone (AU 8 - 17908) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47933	EXOSTOSIS OF SMALL BONE, excision of, including simple removal of bunion and any associated bursa (AU 6 - 17906) **Fee:** $147.50 **Benefit:** 75% = $110.65 85% = $125.40
47936	EXOSTOSIS OF LARGE BONE, excision of (AU 7 - 17907) **Fee:** $181.05 **Benefit:** 75% = $135.80 85% = $153.90
47939	LIMB LENGTHENING (first stage), osteotomy for, including application of distracting apparatus (AU 12 - 17912) **Fee:** $569.95 **Benefit:** 75% = $427.50 85% = $542.25
47942	LIMB LENGTHENING (second stage) internal fixation with bone grafting, including removal of distracting apparatus (AU 12 - 17912) **Fee:** $569.95 **Benefit:** 75% = $427.50 85% = $542.25
47943	LIMB LENGTHENING requiring slow distraction and application of ring fixator, not being a service to which item 47939 applies (AU 26 - 17926) **Fee:** $909.80 **Benefit:** 75% = $682.35 85% = $882.10
47945	DISTRACTING APPARATUS, removal of, without internal fixation (AU 6 - 17906) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital or approved day hospital facility (AU 6 - 17906) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90

47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (AU 7 - 17907) **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
47954	TENDON, large rupture, repair of, not being a service to which another item in this Group applies (AU 10 - 17910) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
47957	TENDON, large, lengthening of, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (AU 4 - 17904) **Fee:** $93.90 **Benefit:** 75% = $70.45 85% = $79.85
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (AU 7 - 17907) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10
47966	TENDON OR LIGAMENT, TRANSFER, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (AU 8 - 17908) **Fee:** $187.75 **Benefit:** 75% = $140.85 85% = $160.05
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (AU 8 - 17908) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (AU 9 - 17909) **Fee:** $262.85 **Benefit:** 75% = $197.15 85% = $235.15
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (AU 7 - 17907) **Fee:** $159.70 **Benefit:** 75% = $119.80 85% = $135.75
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:** $107.15 **Benefit:** 75% = $80.40 85% = $91.10
	BONE GRAFTS
48200	FEMUR, bone graft to (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
48203	FEMUR, bone graft to, with internal fixation (AU 14 - 17914) **Fee:** $650.40 **Benefit:** 75% = $487.80 85% = $622.70
48206	TIBIA, bone graft to (AU 10 - 17910) **Fee:** $402.70 **Benefit:** 75% = $302.05 85% = $375.00
48209	TIBIA, bone graft to, with internal fixation (AU 12 - 17912) **Fee:** $516.30 **Benefit:** 75% = $387.25 85% = $488.60
48212	HUMERUS, bone graft to (AU 10 - 17910) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
48215	HUMERUS, bone graft to, with internal fixation (AU 12 - 17912) **Fee:** $516.30 **Benefit:** 75% = $387.25 85% = $488.60
48218	RADIUS AND ULNA, bone graft to (AU 10 - 17910) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75

48224	RADIUS OR ULNA, bone graft to (AU 10 - 17910) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (AU 11 - 17911) **Fee:** $348.70 **Benefit:** 75% = $261.55 85% = $321.00
48230	SCAPHOID, bone graft to, for non union (AU 10 - 17910) **Fee:** $301.75 **Benefit:** 75% = $226.35 85% = $274.05
48233	SCAPHOID, bone graft to, for non union, with internal fixation (AU 10 - 17910) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (AU 11 - 17911) **Fee:** $569.95 **Benefit:** 75% = $427.50 85% = $542.25
48239	BONE GRAFT, not being a service to which another item in this Group applies (AU 10 - 17910) **Fee:** $315.15 **Benefit:** 75% = $236.40 85% = $287.45
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (AU 11 - 17911) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
	OSTEOTOMY OR OSTEECTOMY
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (AU 7 - 17907) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation (AU 8 - 17908) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $341.10
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of (AU 9 - 17909) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation (AU 10 - 17910) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $341.10
48412	HUMERUS, osteotomy or osteectomy of (AU 11 - 17911) **Fee:** $449.25 **Benefit:** 75% = $336.95 85% = $421.55
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation (AU 12 - 17912) **Fee:** $569.95 **Benefit:** 75% = $427.50 85% = $542.25
48418	TIBIA, osteotomy or osteectomy of (AU 9 - 17909) **Fee:** $449.25 **Benefit:** 75% = $336.95 85% = $421.55
48421	TIBIA, osteotomy or osteectomy of, with internal fixation (AU 12 - 17912) **Fee:** $569.95 **Benefit:** 75% = $427.50 85% = $542.25
48424	FEMUR OR PELVIS, osteotomy or osteectomy of (AU 15 - 17915) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation (AU 17 - 17917) **Fee:** $650.40 **Benefit:** 75% = $487.80 85% = $622.70
	EPIPHYSIODESIS
48500	FEMUR, epiphysiodesis of (AU 11 - 17911) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
48503	TIBIA AND FIBULA, epiphysiodesis of (AU 11 - 17911) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00

48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (AU 15 - 17915) **Fee:** $348.70 **Benefit:** 75% = $261.55 85% = $321.00
48509	EPIPHYSIODESIS, staple arrest of hemi-epiphysis (AU 10 - 17910) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (AU 15 - 17915) **Fee:** $637.00 **Benefit:** 75% = $477.75 85% = $609.30
	SPINE
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital or approved day hospital facility (AU 6 - 17906) **Fee:** $67.05 **Benefit:** 75% = $50.30 85% = $57.00
48603	SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital or approved day hospital facility, not being a service associated with a service to which item 48600 or 50115 applies (AU 6 - 17906) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (AU 24 - 17924) **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
48609	SCOLIOSIS or KYPHOSIS, spinal fusion for, using Harrington or other nonsegmental fixation (AU 24 - 17924) **Fee:** $1,173.45 **Benefit:** 75% = $880.10 85% =$1,145.75
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (AU 30 - 17930) **Fee:** $1,743.40 **Benefit:** 75% =$1,307.55 85% =$1,715.70
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (AU 14 - 17914) **Fee:** $315.15 **Benefit:** 75% = $236.40 85% = $287.45
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (AU 26 - 17926) **Fee:** $1,743.40 **Benefit:** 75% =$1,307.55 85% =$1,715.70
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (AU 26 - 17926) **Fee:** $1,139.90 **Benefit:** 75% = $854.95 85% =$1,112.20
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (AU 30 - 17930) **Fee:** $1,408.15 **Benefit:** 75% =$1,056.15 85% =$1,380.45
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (AU 30 - 17930) **Fee:** $1,810.45 **Benefit:** 75% =$1,357.85 85% =$1,782.75
48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (AU 30 - 17930) **Fee:** $2,011.60 **Benefit:** 75% =$1,508.70 85% =$1,983.90
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (AU 30 - 17930) **Fee:** $1,112.00 **Benefit:** 75% = $834.00 85% =$1,084.30
48636	PERCUTANEOUS LUMBAR DISCECTOMY, 1 or more levels (AU 9 - 17909) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $548.95
48639	VERTEBRAL BODY, total or sub-total excision of, including bone grafting or other form of fixation (AU 28 - 17928) **Fee:** $972.30 **Benefit:** 75% = $729.25 85% = $944.60
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (AU 16 - 17916) **Fee:** $569.95 **Benefit:** 75% = $427.50 85% = $542.25

48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (AU 18 - 17918) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (AU 16 - 17916) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (AU 18 - 17918) **Fee:** $1,072.85 **Benefit:** 75% = $804.65 85% =$1,045.15
48654	SPINAL FUSION (posterior interbody), with laminectomy, 1 level (AU 18 - 17918) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
48657	SPINAL FUSION (posterior interbody), with laminectomy, more than 1 level (AU 21 - 17921) **Fee:** $1,072.85 **Benefit:** 75% = $804.65 85% =$1,045.15
48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (AU 18 - 17918) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (AU 18 - 17918) **Fee:** $576.65 **Benefit:** 75% = $432.50 85% = $548.95
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon **Fee:** $348.70 **Benefit:** 75% = $261.55 85% = $321.00
48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (AU 20 - 17920) **Fee:** $1,039.35 **Benefit:** 75% = $779.55 85% =$1,011.65
48672	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (AU 20 - 17920) **Fee:** $777.85 **Benefit:** 75% = $583.40 85% = $750.15
48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon **Fee:** $469.40 **Benefit:** 75% = $352.05 85% = $441.70
48678	SPINE, simple internal fixation of, involving 1 or more of facetal screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (AU 16 - 17916) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
48681	SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply (AU 16 - 17916) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
48684	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 1 or 2 levels (AU 16 - 17916) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
48687	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (AU 20 - 17920) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
48690	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (AU 22 - 17922) *(See para T8.46 of explanatory notes to this Category)* **Fee:** $1,072.85 **Benefit:** 75% = $804.65 85% =$1,045.15

	SHOULDER
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (AU 10 - 17910) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
48903	SHOULDER, decompression of subacromial space by acromionectomy, excision of coraco-acromial ligament and distal clavicle, or any combination (AU 14 - 17914) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (AU 14 - 17914) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromionectomy, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (AU 15 - 17915) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
48912	SHOULDER - arthrotomy of (AU 9 - 17909) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
48915	SHOULDER, hemi-arthroplasty of (AU 14 - 17914) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (AU 17 - 17917) **Fee:** $1,072.85 **Benefit:** 75% = $804.65 85% =$1,045.15
48921	SHOULDER, total replacement arthroplasty, revision of (AU 17 - 17917) **Fee:** $1,106.40 **Benefit:** 75% = $829.80 85% =$1,078.70
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (AU 23 - 17923) **Fee:** $1,274.05 **Benefit:** 75% = $955.55 85% =$1,246.35
48927	SHOULDER prosthesis, removal of (AU 10 - 17910) **Fee:** $261.50 **Benefit:** 75% = $196.15 85% = $233.80
48930	SHOULDER, anterior stabilisation procedure for recurrent dislocation (AU 13 - 17913) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
48933	SHOULDER, stabilisation procedure for multi-directional instability (AU 15 - 17915) **Fee:** $704.05 **Benefit:** 75% = $528.05 85% = $676.35
48936	SHOULDER, synovectomy of, as an independent procedure (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
48939	SHOULDER, arthrodesis of (AU 16 - 17916) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
48942	SHOULDER, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (AU 18 - 17918) **Fee:** $1,005.80 **Benefit:** 75% = $754.35 85% = $978.10
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (AU 7 - 17907) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (AU 12 - 17912) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromionplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (AU 12 - 17912) **Fee:** $637.00 **Benefit:** 75% = $477.75 85% = $609.30

48954	SHOULDER, arthroscopic total synovectomy of - not being a service associated with any other arthroscopic procedure of the shoulder region (AU 12 - 17912) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability - not being a service associated with any other arthroscopic procedure of the shoulder region (AU 14 - 17914) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
48960	SHOULDER, arthroscopic reconstruction of, including repair of rotator cuff - not being a service associated with any other arthroscopic procedure of the shoulder region (AU 14 - 17914) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
	ELBOW
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (AU 11 - 17911) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
49103	ELBOW, ligamentous stabilisation of (AU 11 - 17911) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
49106	ELBOW, arthrodesis of (AU 13 - 17913) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
49109	ELBOW, total synovectomy of (AU 13 - 17913) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
49112	ELBOW, silastic or other replacement of radial head (AU 13 - 17913) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
49115	ELBOW, total joint replacement of (AU 19 - 17919) **Fee:** $804.65 **Benefit:** 75% = $603.50 85% = $776.95
49118	ELBOW, diagnostic arthroscopy of, including biopsy (AU 7 - 17907) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
49121	ELBOW, arthroscopic surgery involving any 1 or more of drilling of defect, removal of loose body or chondroplasty - not being a service associated with any other arthroscopic procedure of the elbow joint (AU 10 - 17910) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
	WRIST
49200	WRIST, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (AU 12 - 17912) **Fee:** $583.35 **Benefit:** 75% = $437.55 85% = $555.65
49203	WRIST, limited arthrodesis of the intercarpal joint, including bone graft (AU 12 - 17912) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
49206	WRIST, excision arthroplasty of, with radial styloidectomy and proximal carpectomy (AU 12 - 17912) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
49209	WRIST, total replacement arthroplasty of (AU 18 - 17918) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
49212	WRIST, arthrotomy of (AU 10 - 17910) **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (AU 12 - 17912) **Fee:** $462.65 **Benefit:** 75% = $347.00 85% = $434.95
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (AU 7 - 17907) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75

49221	WRIST, arthroscopic surgery of, involving any 1 or more of drilling of defect, removal of loose body, local synovectomy or debridement - not being a service associated with any other arthroscopic procedure of the wrist joint (AU 12 - 17912) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
49224	WRIST, arthroscopic debridement of or total synovectomy of - not being a service associated with any other arthroscopic procedure of the wrist joint (AU 12 - 17912) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
49227	WRIST, arthroscopic pinning of osteochondral fragment - not being a service associated with any other arthroscopic procedure of the wrist joint (AU 12 - 17912) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
	HIP
49300	SACRO-ILIAC JOINT - arthrodesis of (AU 16 - 17916) **Fee:** $371.25 **Benefit:** 75% = $278.45 85% = $343.55
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (AU 11 - 17911) **Fee:** $388.90 **Benefit:** 75% = $291.70 85% = $361.20
49306	HIP - arthrodesis of (AU 20 - 17920) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (AU 16 - 17916) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (AU 16 - 17916) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
49315	HIP, arthroplasty of, unipolar or bipolar (AU 13 - 17913) **Fee:** $603.50 **Benefit:** 75% = $452.65 85% = $575.80
49318	HIP, total replacement arthroplasty of, including minor bone grafting (AU 18 - 17918) **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (AU 20 - 17920) **Fee:** $1,139.90 **Benefit:** 75% = $854.95 85% =$1,112.20
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (AU 22 - 17922) **Fee:** $1,341.10 **Benefit:** 75% =$1,005.85 85% =$1,313.40
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (AU 22 - 17922) **Fee:** $1,542.25 **Benefit:** 75% =$1,156.70 85% =$1,514.55
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (AU 22 - 17922) **Fee:** $1,542.25 **Benefit:** 75% =$1,156.70 85% =$1,514.55
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (AU 24 - 17924) **Fee:** $1,743.40 **Benefit:** 75% =$1,307.55 85% =$1,715.70
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (AU 22 - 17922) **Fee:** $254.80 **Benefit:** 75% = $191.10 85% = $227.10
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cms in length (AU 24 - 17924) **Fee:** $1,978.10 **Benefit:** 75% =$1,483.60 85% =$1,950.40

49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (AU 24 - 17924) **Fee:** $1,978.10 **Benefit:** 75% =$1,483.60 85% =$1,950.40
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (AU 26 - 17926) **Fee:** $2,346.90 **Benefit:** 75% =$1,760.20 85% =$2,319.20
49348	HIP, congenital dislocation of, treatment of, by closed reduction (AU 5 - 17905) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
49351	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (AU 5 - 17905) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
49354	HIP, congenital dislocation of, open reduction of (AU 8 - 17908) **Fee:** $603.50 **Benefit:** 75% = $452.65 85% = $575.80
49357	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (AU 8 - 17908) **Fee:** $252.70 **Benefit:** 75% = $189.55 85% = $225.00
	KNEE
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (AU 10 - 17910) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
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:** $348.70 **Benefit:** 75% = $261.55 85% = $321.00
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:** $523.00 **Benefit:** 75% = $392.25 85% = $495.30
49509	KNEE, total synovectomy or arthrodesis of (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
49512	KNEE, arthrodesis of, with removal of prosthesis (AU 13 - 17913) **Fee:** $771.10 **Benefit:** 75% = $578.35 85% = $743.40
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (AU 9 - 17909) **Fee:** $603.50 **Benefit:** 75% = $452.65 85% = $575.80
49517	KNEE, hemiarthroplasty of (AU 20 - 17920) **Fee:** $859.25 **Benefit:** 75% = $644.45 85% = $831.55
49518	KNEE, total replacement arthroplasty of (AU 18 - 17918) **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (AU 19 - 17919) **Fee:** $1,139.90 **Benefit:** 75% = $854.95 85% =$1,112.20
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (AU 20 - 17920) **Fee:** $1,341.10 **Benefit:** 75% =$1,005.85 85% =$1,313.40
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (AU 21 - 17921) **Fee:** $1,139.90 **Benefit:** 75% = $854.95 85% =$1,112.20
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (AU 22 - 17922) **Fee:** $1,408.15 **Benefit:** 75% =$1,056.15 85% =$1,380.45

49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (AU 23 - 17923) **Fee:** $1,609.30 **Benefit:** 75% =$1,207.00 85% =$1,581.60
49536	KNEE, repair or reconstruction of, for chronic instability involving either cruciate or collateral ligaments (AU 15 - 17915) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
49539	KNEE, reconstructive surgery of cruciate ligaments (open or arthroscopic, or both), including surgery to other internal derangements, not being a service to which another item in this Group applies (AU 13 - 17913) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
49542	KNEE, reconstructive surgery to cruciate ligaments (open or arthroscopic, or both), including meniscus repair, extracapsular procedure and debridement when performed (AU 14 - 17914) **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
49545	KNEE, revision arthrodesis of (AU 15 - 17915) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
49548	KNEE, revision of patello-femoral stabilisation (AU 11 - 17911) **Fee:** $670.55 **Benefit:** 75% = $502.95 85% = $642.85
49551	KNEE, revision of procedures to which item 49536, 49539 or 49542 applies (AU 15 - 17915) **Fee:** $938.75 **Benefit:** 75% = $704.10 85% = $911.05
49554	KNEE, revision total knee replacement of, by anatomic specific allograft of tibia or femur (AU 23 - 17923) **Fee:** $1,341.10 **Benefit:** 75% =$1,005.85 85% =$1,313.40
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with any other arthroscopic procedure of the knee region (AU 7 - 17907) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
49560	KNEE, arthroscopic surgery of, involving any 1 or more of: meniscectomy, removal of loose body, lateral release, or chondroplasty - not being a service associated with any other arthroscopic procedure of the knee region (AU 10 - 17910) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
49563	KNEE, arthroscopic surgery of, involving meniscus repair or osteoplasty, or both (AU 10 - 17910) **Fee:** $637.00 **Benefit:** 75% = $477.75 85% = $609.30
49566	KNEE, arthroscopic total synovectomy of (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
	ANKLE
49700	ANKLE, diagnostic arthroscopy of, including biopsy (AU 8 - 17908) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
49703	ANKLE, arthroscopic surgery of (AU 12 - 17912) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
49706	ANKLE, arthrotomy of, involving 1 or more of; lavage, removal of loose body or division of contracture (AU 10 - 17910) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
49709	ANKLE, ligamentous stabilisation of (AU 11 - 17911) **Fee:** $502.90 **Benefit:** 75% = $377.20 85% = $475.20
49712	ANKLE, arthrodesis of (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
49715	ANKLE, total joint replacement of (AU 17 - 17917) **Fee:** $804.65 **Benefit:** 75% = $603.50 85% = $776.95
49718	ANKLE, Achilles' tendon or other major tendon, repair of (AU 10 - 17910) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50

49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment **Fee:** $167.65 **Benefit:** 75% = $125.75 85% = $142.55
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (AU 11 - 17911) **Fee:** $469.40 **Benefit:** 75% = $352.05 85% = $441.70
49727	ANKLE, Achilles' tendon, operation for lengthening (AU 10 - 17910) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
	FOOT
49800	FOOT, flexor or extensor tendon, primary repair of (AU 9 - 17909) **Fee:** $93.90 **Benefit:** 75% = $70.45 85% = $79.85
49803	FOOT, flexor or extensor tendon, secondary repair of (AU 9 - 17909) **Fee:** $120.70 **Benefit:** 75% = $90.55 85% = $102.60
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (AU 4 - 17904) **Fee:** $93.90 **Benefit:** 75% = $70.45 85% = $79.85
49809	FOOT, open tenotomy of, with or without tenoplasty (AU 7 - 17907) **Fee:** $154.20 **Benefit:** 75% = $115.65 85% = $131.10
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (AU 10 - 17910) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
49815	FOOT, triple arthrodesis of (AU 12 - 17912) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
49818	FOOT, excision of calcaneal spur (AU 6 - 17906) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Kellers or similar procedure) - unilateral (AU 9 - 17909) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Kellers or similar procedure) - bilateral (AU 10 - 17910) **Fee:** $539.80 **Benefit:** 75% = $404.85 85% = $512.10
49827	FOOT, correction of hallux valgus and transfer of adductor hallucis tendon - unilateral (AU 10 - 17910) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
49830	FOOT, correction of hallux valgus and transfer of adductor hallucis tendon - bilateral (AU 12 - 17912) **Fee:** $586.70 **Benefit:** 75% = $440.05 85% = $559.00
49833	FOOT, correction of hallux valgus by osteotomy of first matatarsal including internal fixation where performed - unilateral (AU 10 - 17910) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $341.10
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (AU 13 - 17913) **Fee:** $637.00 **Benefit:** 75% = $477.75 85% = $609.30
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (AU 11 - 17911) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $341.10
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (AU 14 - 17914) **Fee:** $637.00 **Benefit:** 75% = $477.75 85% = $609.30
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint (AU 10 - 17910) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55

49848	FOOT, correction of claw or hammer toe (AU 8 - 17908) **Fee:** $114.00 **Benefit:** 75% = $85.50 85% = $96.90
49851	FOOT, correction of claw or hammer toe with internal fixation (AU 8 - 17908) **Fee:** $147.50 **Benefit:** 75% = $110.65 85% = $125.40
49854	FOOT, radical plantar fasciotomy or fasciectomy of (AU 9 - 17909) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
49857	FOOT, metatarso-phalangeal joint replacement (AU 12 - 17912) **Fee:** $248.10 **Benefit:** 75% = $186.10 85% = $220.40
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (AU 9 - 17909) **Fee:** $201.15 **Benefit:** 75% = $150.90 85% = $173.45
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (AU 11 - 17911) **Fee:** $301.75 **Benefit:** 75% = $226.35 85% = $274.05
49866	FOOT, neurectomy for plantar digital neuritis (Morton's or Bett's syndrome) (AU 7 - 17907) **Fee:** $214.55 **Benefit:** 75% = $160.95 85% = $186.85
49869	TALIPES EQUINOVARUS, posterior release of (AU 8 - 17908) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
49872	TALIPES EQUINOVARUS, medial release of (AU 8 - 17908) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
49875	TALIPES EQUINOVARUS, combined postero-medial release of (AU 9 - 17909) **Fee:** $402.30 **Benefit:** 75% = $301.75 85% = $374.60
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (AU 6 - 17906) **Fee:** $40.25 **Benefit:** 75% = $30.20 85% = $34.25
	OTHER JOINTS
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (AU 8 - 17908) **Fee:** $194.45 **Benefit:** 75% = $145.85 85% = $166.75
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $234.70 **Benefit:** 75% = $176.05 85% = $207.00
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (AU 9 - 17909) **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $194.70
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (AU 10 - 17910) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies (AU 11 - 17911) **Fee:** $335.25 **Benefit:** 75% = $251.45 85% = $307.55
50112	JOINT, CICATRICIAL FLEXION CONTRACTURE OF, correction of, involving tissues deeper than skin and subcutaneous tissue (AU 10 - 17910) **Fee:** $268.20 **Benefit:** 75% = $201.15 85% = $240.50
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital or approved day hospital facility, not being a service associated with a service to which another item in this Group applies (AU 4 - 17904) **Fee:** $100.60 **Benefit:** 75% = $75.45 85% = $85.55
50118	SUBTALAR JOINT, arthrodesis of (AU 11 - 17911) **Fee:** $308.45 **Benefit:** 75% = $231.35 85% = $280.75

50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (AU 13 - 17913) **Fee:** $603.50 **Benefit:** 75% = $452.65 85% = $575.80
50124	JOINT or other SYNOVIAL CAVITY, aspiration of, injection into, or both of these procedures; payable on not more than 25 occasions in any 12 month period (AU 5 - 17905) **Fee:** $21.10 **Benefit:** 75% = $15.85 85% = $17.95
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (AU 15 - 17915) **Fee:** $500.40 **Benefit:** 75% = $375.30 85% = $472.70
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (AU 9 - 17909) **Fee:** $222.40 **Benefit:** 75% = $166.80 85% = $194.70
	MALIGNANT DISEASE
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (AU 5 - 17905) **Fee:** $134.10 **Benefit:** 75% = $100.60 85% = $114.00
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (AU 8 - 17908) **Fee:** $295.05 **Benefit:** 75% = $221.30 85% = $267.35
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of; liquid nitrogen freezing, autograft, allograft or cementation (AU 9 - 17909) **Fee:** $435.85 **Benefit:** 75% = $326.90 85% = $408.15
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of; liquid nitrogen freezing, autograft, allograft or cementation (AU 10 - 17910) **Fee:** $536.45 **Benefit:** 75% = $402.35 85% = $508.75
50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (AU 19 - 17919) **Fee:** $1,173.45 **Benefit:** 75% = $880.10 85% =$1,145.75
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (AU 21 - 17921) **Fee:** $1,475.20 **Benefit:** 75% =$1,106.40 85% =$1,447.50
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint (AU 21 - 17921) **Fee:** $1,944.55 **Benefit:** 75% =$1,458.45 85% =$1,916.85
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (AU 22 - 17922) **Fee:** $1,810.45 **Benefit:** 75% =$1,357.85 85% =$1,782.75
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (AU 25 - 17925) **Fee:** $2,011.60 **Benefit:** 75% =$1,508.70 85% =$1,983.90
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (AU 27 - 17927) **Fee:** $2,346.90 **Benefit:** 75% =$1,760.20 85% =$2,319.20
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (AU 19 - 17919) **Fee:** $1,206.95 **Benefit:** 75% = $905.25 85% =$1,179.25
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (AU 26 - 17926) **Fee:** $1,542.25 **Benefit:** 75% =$1,156.70 85% =$1,514.55
50236	MALIGNANT TUMOUR, amputation for, hip dis-articulation, shoulder dis-articulation or proximal third femur (AU 20 - 17920) **Fee:** $1,206.95 **Benefit:** 75% = $905.25 85% =$1,179.25

50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (AU 13 - 17913) **Fee:** $804.65 **Benefit:** 75% = $603.50 85% = $776.95

GROUP T9 - ASSISTANCE AT OPERATIONS

NOTE: *Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner.*

51300	Assistance at any operation for which the fee exceeds $180.90 but does not exceed $321.35 or at a series or a combination of operations where the fee for at least 1 of the operations exceeds $180.90 but where the fee for the series or combination of operations does not exceed $321.35 **Fee:** $61.45 **Benefit:** 75% = $46.10 85% = $52.25
51303	Assistance at any operation for which the fee exceeds $321.35 or at a combination of operations for which the aggregate fee exceeds $321.35 provided that the fee for at least 1 of the operations exceeds $180.90 **Derived Fee:** one fifth of the established fee for the operation or combination of operations
51306	Assistance at a delivery involving Caesarean section **Fee:** $88.85 **Benefit:** 75% = $66.65 85% = $75.55
51309	Assistance at a series or combination of operations, 1 of which is a delivery involving Caesarean section **Derived Fee:** one fifth of the established fee for the operation or combination of operations ($444.25 being the Schedule fee for the Caesarean section component in the calculation of the established fee)

MEDICARE BENEFITS ADVISORY COMMITTEE (MBAC)

RECOMMENDATIONS

MEDICARE BENEFITS ADVISORY COMMITTEE (MBAC) RECOMMENDATIONS
(see paragraph 10.1 of the General Explanatory Notes)

	ANAESTHETICS
17971(01)	ADMINISTRATION OF AN ANAESTHETIC ASSOCIATED with pharyngotomy with excision of tongue - FOURTEEN UNITS **Fee:** $183.05 **Benefit:** 75% = $137.30: 85% = $155.60
17971(02)	ADMINISTRATION OF AN ANAESTHETIC ASSOCIATED with removal of keratoses, warts or similar lesions **Fee:** Derived Fee - 3 Basic units plus 1 unit for each 15 minutes
	OPERATIONS
30000(79)	EXTRACTION OF CALCULUS FROM BILIARY OR RENAL TRACT - using interventional imaging techniques - not associated with Items 36627, 36630, 36645, 36648 (AU 11 - 17971(79)) **Fee:** $372.95 **Benefit:** 75% = $279.70: 85% = $345.25
30000(135)	EXCISION OF FRENULUM OF TONGUE AND REPAIR under general anaesthesia (AU 6 - 17971(135)) **Fee:** $85.90 **Benefit:** 75% = $64.45: 85% = $73.00
30000(136)	URETHRAL CATHETERISATION, BLADDER LAVAGE AND HYDROSTATIC DILATATION, including any associated consultation **Fee:** $65.55 **Benefit:** 75% = $49.15: 85% = $55.70
30000(145)	BALLOON VALVULOPLASTY OR SEPTOSTOMY including cardiac catheterisations before and after balloon dilatation (AU 16 - 17971(145)) **Fee:** $649.80 **Benefit:** 75% = $487.35: 85% = $622.10
30000(157)	OPEN HEART SURGERY, with arterial switch procedure for transposition of great vessels (AU 32 - 17971(157)) **Fee:** $2,661.35 **Benefit:** 75% = $1,996.00: 85% = $2,633.65
30000(174)	SURGICAL CONTROL OF DROOLING, relocation of both submandibular ducts (AU 16 - 17971(174)) **Fee:** $791.05 **Benefit:** 75% = $593.30: 85% = $763.35
30000(179)	EXCISION OF HYDATID CYST OF THE LIVER with drainage and excision of liver tissue (AU 18 - 17971(179)) **Fee:** $627.20 **Benefit:** 75% = $470.40: 85% = $599.50
30000(180)	DILATION OF RECTAL STRICTURE (AU 5 - 17971(180)) **Fee:** $90.40 **Benefit:** 75% = $67.80: 85% = $76.85
30000(184)	LARYNGEAL WEB, division of, using microlaryngoscopic techniques (AU 9 - 17971(184)) **Fee:** $276.85 **Benefit:** 75% = $207.65: 85% = $249.15
30000(185)	REPAIR OF VAGINO-PERINEAL FISTULA under general anaesthesia (AU 7 - 17971(185)) **Fee:** $144.65 **Benefit:** 75% = $108.50: 85% = $122.95
30000(188)	REMOVAL OF TENCKHOFF PERITONEAL DIALYSIS CATHETER, (including catheter cuffs) (AU 7 - 17971(188)) **Fee:** $162.75 **Benefit:** 75% = $122.05: 85% = $138.35
30000(191)	STERNUM, REWIRING of (AU 9 - 17971(191)) **Fee:** $288.20 **Benefit:** 75% = $216.15: 85% = $260.50
30000(205)	OVARIAN CYST(S), TRANS-VAGINAL DRAINAGE using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (AU 7 - 17971(205)) **Fee:** $201.15 **Benefit:** 75% = $150.85: 85% = $173.45

	MBAC
30000(208)	REPLACEMENT OF OCCLUDED NON-INFECTED PROSTHETIC BY-PASS GRAFT FROM TRUNK, including closure of vessel or vessels (AU 26 - 17971(208) **Fee:** $570.70 **Benefit:** 75% = $428.00: 85% = $543.00
30000(210)	FOETAL BLOOD SAMPLING - using interventional imaging techniques (AU 7 - 17971(210)) **Fee:** $201.15 **Benefit:** 75% = $150.85: 85% = $173.45
30000(212)	MANDIBLE, FIXATION BY INTERMAXILLARY WIRING, excluding wiring for obesity **Fee:** $171.80 **Benefit:** 75% = $128.85: 85% = $146.05
30000(225)	BONE GROWTH STIMULATOR, insertion of (AU 8 - 17971(225)) **Fee:** $271.20 **Benefit:** 75% = $203.40: 85% = $243.50
30000(226)	FORAGE, (Drill decompression), OF NECK AND/OR HEAD OF FEMUR (AU 8 - 17971(226)) **Fee:** $259.90 **Benefit:** 75% = $194.90: 85% = $232.20
30000(227)	FORAGE, (Drill decompression), OF NECK AND/OR HEAD OF FEMUR, in association with pressure testing (AU 9 - 17971(227)) **Fee:** $288.20 **Benefit:** 75% = $216.15: 85% = $260.50
30000(229)	SYNOVECTOMY OF ANKLE, or EXTENSOR or FLEXOR TENDON OF ANKLE - one or more of (AU 9 - 17971(229)) **Fee:** $389.90 **Benefit:** 75% = $292.40: 85% = $362.20
30000(230)	MASTOIDECTOMY, radical or modified radical, obliteration of the mastoid cavity, blind sac closure of external auditory canal and obliteration of eustachian tube (AU 16 - 17971(230)) **Fee:** $1,361.75 **Benefit:** 75% = $1021.30: 85% = $1,334.05
30000(238)G 30000(239)S	BLADDER STRESS INCONTINENCE, vaginal procedure for (AU 10 - 17971(238/239)) **Fee:** $322.05 **Benefit:** 75% = $241.55: 85% = $294.35 **Fee:** $372.95 **Benefit:** 75% = $279.70: 85% = $345.25
30000(246)	BALLOON DILATATION OF OESOPHAGUS using interventional imaging techniques (AU 8 - 17971(246)) **Fee:** $162.75 **Benefit:** 75% = $122.05: 85% = $138.35
30000(248)	MYOCARDIAL BIOPSY BY CARDIAC CATHETERISATION (AU 7 - 17971(248)) **Fee:** $212.45 **Benefit:** 75% = $159.35: 85% = $184.75
30000(250)	NASAL SEPTUM, RECONSTRUCTION of (AU 9 - 17971(250)) **Fee:** $429.45 **Benefit:** 75% = $322.10: 85% = $401.75
30000(254)	PAROTID DUCT, repair of, using micro-surgical techniques (AU 14 - 17971(254)) **Fee:** $491.60 **Benefit:** 75% = $368.70: 85% = $463.90
30000(256)	ANEURYSM, thoracicaortic resection and grafting (AU 42 - 17971(256)) **Fee:** $1,254.40 **Benefit:** 75% = $940.80: 85% = $1,226.70
30000(258)	FULL THICKNESS LACERATION of lip with separate apposition of each layer (AU 7 - 17971(258)) **Fee:** $180.80 **Benefit:** 75% = $135.60: 85% = $153.70
30000(259)	CLITOROPLASTY, with relocation of urethral orifice, reduction of (AU 16 - 17971(259)) **Fee:** $593.30 **Benefit:** 75% = $444.95: 85% = $565.60
30000(260)	MITROFANOFF CONTINENT VALVE, formation of (AU 20 - 17971(260)) **Fee:** $1017.60 **Benefit:** 75% = $763.20: 85% = $989.90
30000(261)	FULL FACE CHEMICAL PEEL for severely sun-damaged skin performed in operating theatre of a hospital or approved day hospital facility (AU 7 - 17971(261)) **Fee:** $282.50 **Benefit:** 75% = $211.85: 85% = $254.80
30000(267)	ULNA, DISTAL, silastic replacement of (AU 9 - 17971(267)) **Fee:** $452.05 **Benefit:** 75% = $339.05: 85% = $424.35
30000(269)	PROSTATIC COIL, insertion of, under ultrasound control (AU 7 - 17971(269)) **Fee:** $146.90 **Benefit:** 75% = $110.15: 85% = $124.85

30000(271)	CYSTOSCOPY with insertion of urethral prosthesis (AU 7 - 17971(271)) **Fee:** $230.30 **Benefit:** 75% = $172.70: 85% = $202.60
30000(274)	BALLOON DILATATION OF URETHRAL STRICTURE - using interventional imaging techniques (AU 5 - 17971(274)) **Fee:** $83.55 **Benefit:** 75% = $62.65: 85% = $71.00
30000(275)	INGROWING FINGERNAIL, wedge resection for (AU 6 - 17971(275)) **Fee:** $119.95 **Benefit:** 75% = $89.95: 85% = $101.95
30000(276)	PHOTOMYDRIASIS, laser **Fee:** $253.40 **Benefit:** 75% = $190.05: 85% = $225.70
30000(277)	PHOTOIRIDOSYNERESIS, laser **Fee:** $253.40 **Benefit:** 75% = $190.05: 85% = $225.70
30000(278)	PHOTOTHERAPEUTIC KERATECTOMY, laser **Fee:** $404.35 **Benefit:** 75% = $303.25: 85% = $376.65
30000(279)	ARTIFICIAL LENS, insertion of, into the posterior chamber and sutured to the iris and sclera (AU 11 - 17971(279)) **Fee:** $384.15 **Benefit:** 75% = $288.10: 85% = $356.45
	RADIOLOGY
60700(17)	PERITONEOGRAM (herniography) with or without ionic or non-ionic contrast medium including preparation - performed on a person over 14 years of age **Fee:** $115.65 **Benefit:** 75% = $86.75: 85% = $98.30
60700(18)	AIR INSUFFLATION during video - fluoroscopic imaging including associated consultation **Fee:** $134.45 **Benefit:** 75% = $100.85: 85% = $114.30
60700(19)	DEFAECOGRAM, paediatric **Fee:** $138.60 **Benefit:** 75% = $103.95: 85% = $117.80
	NUCLEAR MEDICINE
61501(1)	RADIONUCLIDE COLON TRANSIT STUDY **Fee:** $582.00 **Benefit:** 75% = $436.50: 85% = $554.30
61501(2)	BRAIN STUDY using Tc-exametazine, and including Single Photon Emission Tomography **Fee:** $486.10 **Benefit:** 75% = $364.55: 85% = $458.40
61501(3)	LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY using Thallium **Fee:** $325.80 **Benefit:** 75% = $244.35: 85% = $298.10
61501(4)	WHOLE BODY STUDY using Thallium **Fee:** $444.75 **Benefit:** 75% = $333.55: 85% = $417.05

INDEX TO
GENERAL MEDICAL SERVICES

PLEASE NOTE:

This index is a reference point for medical services which attract Medicare benefits under items included in the Schedule of General Medical Services. Medical practitioners should peruse the actual description of the item in the Schedule to ensure the correct item number is selected and to ascertain whether there are any restrictions relating to the payment of benefits. Restrictions are, as far as practicable, included in the description of the item. Otherwise they will be outlined in the notes immediately preceding the particular Category of the Schedule.

* Payable on attendance basis

Service	Item
arthroscopy of, diagnostic	49700
arthrotomy of	49706
dislocation, treatment of	47063,47066
fracture, treatment of	47594-47603
ligamentous stabilisation of	49709
major tendon repair	49718
total joint replacement	49715
Anophthalmic orbit, insertion cartilage/implant	42518
orbit, removal of implant from socket	42518
socket, treatment as secondary procedure	42521
Anoplasty for anal stricture	32123
Anorectal carcinoma, excision of	32105
examination, under GA	32171
malformation, perineal anoplasty	43839
malformation, rectoplasty	43842
sensation, measurement of	11830
Antenatal cardiotocography (restriction)	16555
care, independent of confinement	16500,16503
Antepartum haemorrhage, treatment of	16542
Anterior chamber, irrigation of blood from	42743
resection of rectum	32024,32027
section of corpus callosum for epilepsy	40700
synechiae, division of	42761
vaginal repair	35575-35580
Antireflux operations	30527,30529,30530
Antrectomy and/or vagotomy	30497,30503
Antrobuccal fistula operation	41722
Antrostomy, radical	41710,41713
Antrum, drainage of, through tooth socket	41719
intranasal, operation on	41716
maxillary, lavage of	41704
maxillary, proof puncture, lavage	41698,41701
removal of foreign body from	41716
Anus, dilatation of (Lord's procedure)	32153
Aorta, anastomosis, congenital heart disease	38706,38709
thoracic, management of rupture/dissection	38572
thoracic, repair/replacement procedures	38550-38571
Aortic endarterectomy	33509
valve, decalcification of	38486
Aorto-duodenal fistula, repair of	34160,34163,34166
Aorto-femoral endarterectomy	33515
grafting	32709
Aorto-iliac endarterectomy	33512
grafting	32709
Appendiceal abscess, laparotomy for drainage	30394
Appendicectomy	30571,30572,30574
Appendicostomy	30375
Appendix, ruptured, laparotomy for drainage	30394
Arachnoidal cyst, craniotomy for	39718
Areola, reconstruction of	45545
Arm, amputation or disarticulation of	44328
Arnold Chiari malformation, decompression of	40106
Arrhythmia surgery	38512-38524
Arterial anastomosis, not otherwise covered	32766,32769
atherectomy, peripheral	35312
cannulation for infusion chemotherapy, open	34524
catheterisation, peripheral	35318,35321
puncture and blood collection, diagnostic	12100
Arteriography, operative	35200
Arteriovenous access device, insertion of	34512
access device, prosthetic, correction of	34518
access device, thrombectomy of	34515
anastomosis of upper or lower limb	34503,34509
fistula, dissection and ligation/repair	34112-34127
fistula, ligation of cervical vessel/s	39812
fistula extremity, surgically created, closure	34130
fistula, stenosis of, correction of	34518
malformation, excision of	45039,45042,45045
malformation, intracranial, embolisation of	39809
malformation, intracranial, excision of	39803
malformation, intracranial artery clipping of	39806
malformation, laminectomy, radical excision of	40318
shunt, declotting of	13106
shunt, external, insertion/removal	34500,34506
Artery, anastomosis of, microvascular	45502
bypass grafting, occlusive arterial disease	32700-32763
coeliac, decompression of	34142
coronary, bypass operations	38497,38500,38503
embolectomy of	33800,33803,33806
endarterectomy of	33500-33542
ethmoidal, transorbital ligation of	41725
great, ligation/exploration, other	34103
ligation/exploration not otherwise covered	34106
major, of neck, ligation/exploration, other	34100
major, repair of wound of	33815-33839
maxillary, transantral ligation of	41707
neck, reoperation for bleeding/thrombosis	33842
patch grafting to	33106,33545,33548
popliteal, exploration for popliteal entrapment	34145
temporal, biopsy of	34109
thrombectomy of	33803,33806
Arthrectomy, hip	49309,49312
Arthrodesis, ankle	49712
elbow	49106
finger/hand	46300,46303
foot	49815,49845
hip	49306
joint, other	50109
knee	49509,49512,49545
sacro-iliac joint	49300
shoulder	48939,48942
subtalar joint	50118
wrist	49200,49203
Arthroplasty, ankle	49715
carpal bone	46324
finger/hand	46306-46321
foot	49839,49842
hip	49309-49333
joint, other	50127
knee	49518-49533
shoulder	48915-48924
temporo-mandibular joint	45758
wrist	49206,49209
Arthroscopy, ankle	49700,49703
elbow	49118,49121
joint, other	50100
knee	49557-49566
shoulder	48945-48960
wrist	49218-49227
Arthrotomy, ankle	49706
elbow	49100
finger/hand	46327,46330
hip	49303
joint, other	50103
knee	49500
shoulder	48912
wrist	49212
Artificial erection device, insertion of	37426,37429
erection device, revision or removal of	37432
insemination	*
lens, insertion of	42701
lens, removal of	42704

* Payable on attendance basis

Service	Item
lens, removal, replacement different lens	42707
lens, repositioning of, open operation	42704
urinary sphincter, insertion	37381,37384,37387
urinary sphincter, revision/removal	37390
Arytenoidectomy with microlaryngoscopy	41867
Aspiration biopsy, bone marrow	30087
biopsy, deep organ, imaging guided	30094
of bladder, needle	37041
of breast cyst	*
of haematoma	30216
of joint, other synovial cavity (restriction)	50124
of thoracic cavity	38400,38403
Assistance at operations	51300-51309
in administration of an anaesthetic	17500
Assisted reproductive technologies	13200-13221
Atherectomy, peripheral arterial	35312
Atresia, choanal, repair of	43803,43806
external auditory canal, reconstruction	45662
oesophagus, correction of	43821
Atrial chamber/s, operations for arrhythmia	38512,38515
septal defect closure	38742
septectomy	38739
Attendance, acupuncture	173
anaesthetist, prior to anaesthesia	17600,17603
consultant physician (not psychiatry)	110-131
consultant psychiatrist	134-159
contact lenses	10801-10815
emergency, after hours (restriction)	97,98
family group therapy	170,171,172
general practitioner	3-51
intensive care unit (specialist)	13809,13812
other non-specialist	52-96
post-operative	(see note T8.7)
prolonged, lifesaving treatment	160-164
specialist	104-108
Atticotomy	41533,41536
Audiogram	11309-11318
impedance	11324,11327,11330
Audiometry, brain stem evoked response	11300
non-determinate	11306
Auditory canal, external	
- reconstruction of	41524
- reconstruction, congenital atresia	45662
- removal of foreign body, incision	41503
canal stenosis, correction of, with meatoplasty	41521
meatus, external, removal of exostoses in	41518
meatus, internal, exploration	41599
Augmentation mammaplasty	45524,45527
Aural polyp, removal of	41506
Austin Moore arthroplasty of hip	49315
Autoconjunctival transplant	42641
Avulsion, penis, repair of	37411
Axilla, lymph glands, excision of	30332,30333
Axillary hyperhidrosis, excision for	30180,30183
to femoral bypass grafting	32715
vessel, ligation/exploration, other	34103
Axillofemoral graft, infected, excision of	34172

B

Baker's cyst, excision of	30114
Bartholin's abscess, incision of	35520
cyst, excision of	35512,35513
cyst or gland, marsupialisation of	35516,35517
Barton's fracture of radius, treatment of	47369,47372,47375
Basal cell carcinoma, removal of	30117-30144
Bassini's operation	30612,30614
Bat ear or similar deformity, correction of	45659
Bicornuate uterus, plastic reconstruction for	35680
Bifurcate graft, aorto-iliac/aorto-femoral	32709
Bile duct, common, radical resection	30461,30463,30464
duct, common, repair of	30472
duct, endoscopic stenting of	30491
duct fistula, repair of, after surgery	30470
Biliary bypass	30460,30466,30467
dilatation, endoscopic	30494
drainage tube exchange, imaging guided	30451
manometry	30493
stricture, repair of	30469
Biopsy, aggressive bone/deep tissue tumour	50200
bone marrow	30081,30084,30087
breast	30360,30363
cervix, cone	35617,35618
drill, lymph gland, deep tissue/organ	30078
endometrial, for suspected malignancy	35624
endometrium	*
laparoscopic	30391
liver	30409,30411
lung, percutaneous needle	38412
lymph gland, muscle, other deep tissue/organ	30074,30075
needle aspiration	*
percutaneous aspiration, deep organ	30094
pleura	30090
prostate	37212,37215,37218
punch, of synovial membrane	30087
rectum, full thickness	32096
renal (closed)	36561
scalene node	30096
skin or mucous membrane	30071
vertebra, needle	30093
Bladder, aspiration of, by needle	37041
biopsy of, with cystoscopy	36836
catheterisation of	36800
cystostomy or cystotomy	37007,37008
diverticulum of, excision or obliteration	37020
ectopic, 'turning-in' operation	43851
enlargement of, using intestine	37047
excision of	37000,37014
extrophy closure	37050
neck, contracted, excision/resection	43845
neck resection, endoscopic	36854
repair of rupture	37003,37004
stress incontinence, suprapubic procedure	37044
transection, with re-anastomosis to trigone	37053
tumour/s, diathermy/resection	36839,36845
tumour/s, suprapubic diathermy of	37017
washout test of	11921
Blepharospasm, injection of botulinus toxin	42827
Block, nerve, regional or field	(see nerve)
Blood, administration of	13703,13706
cell separation	*
collection of, for pathology test	12100,13312
collection of, for transfusion	13709
dye - dilution indicator test	11715
pressure monitoring, indwelling catheter (ICU)	13819
pressure monitoring, intravascular cannula	11600
transfusion	13703,13706
transfusion, paediatric/neonatal	13306,13309,13315
volume estimation, nuclear	12500
Bone, cysts, injection into or aspiration of	47900
flap, infected, craniectomy for	39906
graft, harvesting of	47726,47729,47732

* Payable on attendance basis

Service	Item
graft to femur	48200,48203
graft to humerus	48212,48215
graft to other bones	48239
graft to phalanx or metacarpal	46402,46405
graft to radius and ulna	48221
graft to radius or ulna	48218,48224,48227
graft to scaphoid	48230,48233,48236
graft to spine	48642-48651
graft to tibia	48206,48209
graft, with internal fixation	48242
marrow, administration of	13706
marrow, aspiration biopsy of	30087
marrow, harvesting of for transplantation	13700
tumour, benign, resection of	50230
tumour, innocent, excision of	30241
tumour, malignant, operations for	50200-50239
Botulinus toxin injection for blepharospasm	42827
toxin injection for strabismus	42830
Boutonniere deformity, reconstruction of	46444,46447
Bowel, large, resection of	32000,32003
mobilisation of	30387
restoration following Hartmann's op	32033
ruptured, repair or removal of	30375
small, intubation	30487,30488
small, resection of	30565,30566
Brachial plexus, exploration of	39333
vessel, ligation/exploration, other	34106
Brachycephaly, cranial vault reconstruction for	45785
Brachytherapy planning	15536
Brain stem evoked response audiometry	11300
stem tumour, craniotomy for removal	39709
Branchial cyst, removal of	30286
fistula, removal of	30289
Breast, biopsy, fine needle, imaging guided	30360
central ducts, excision for benign condition	30367
core biopsy of solid tumour or tissue	30363
cyst, aspiration of	*
cyst, excision of	30341-30346
exploration/drainage, operating theatre	30364
lesion, pre-op localisation, imaging guided	30361
mammaplasty	45521,45524,45527
manipulation tissue surrounding prosthesis	*
mastectomy	(see mastectomy)
microdochotomy	30366
nipple, accessory, excision of	30372
prosthesis operations	45548-45554
reconstruction	45530-45542
tissue, accessory, excision of	30369
Broad ligament cyst/tumour, excision/removal	35712-35717
Brodie's abscess, operation for	43515
Bronchial tree, intrathoracic operation on, other	38456
Bronchoscopy, as an independent procedure	41889
fibreoptic	41898
with biopsy or other procedure	41892
with dilatation of tracheal stricture	41904
Bronchospirometry	11500
Bronchus, operations on	41889,41892,41895
removal of foreign body in	41895
Broviac catheter, insertion of, for chemotherapy	34527
catheter, removal of	34530
Bubonocele operation	30612,30614
Bunion, excision of	47933
Burns, dressing of (not involving grafting)	30003-30014
excision of under GA (not involving grafting)	30017,30020
free grafting	45406-45436
Burr-hole craniotomy, intracranial haemorrhage	39600
placement of intracranial electrodes	40709
single, preparatory to ventricular puncture	39012
Bursa, incision of	*
large, excision of	30110,30111
semimembranosus, excision of	30114
small, excision of	30106,30107
Burst abdomen, repair of	30403
Bypass, extracranial to intracranial	39818
graft, infected, of extremities, excision of	34175
graft, infected, of neck, excision of	34157
graft, infected, of trunk, excision of	34169
grafting, arterial, for occlusive arterial disease	32700-32763
grafting, cross leg, saphenous to iliac or femoral vein	34806

C

Caecostomy, involving laparotomy	30375
closure of	30562
Caesarean section	16520
Calcaneal spur, of foot, excision of	49818
Calcanean bursa, excision of	30110,30111
Calcaneum fracture, treatment of	47606-47618
Calculus, bladder, removal of	36863
kidney, removal of	36540,36543
staghorn, nephrolithotomy and/or pyelolithotomy	36543
sublingual/salivary gland duct, removal of	30265,30266
ureter, removal of	36549
ureteric, endoscopic removal/manipulation	36857
Caldwell-Luc operation	41710
Calf, decompression fasciotomy of	47975,47978,47981
Caloric test of labyrinth(s)	11333,11336
Cancer of skin/mucous membrane, removal	30196-30205
Cannulation, arterial, for infusion chemotherapy	34524
for cardiopulmonary bypass	38600,38603
intra-abdominal vessel, for chemotherapy	34521
of a vein in a neonate	13300
Canthoplasty	42590
Capsule, posterior, needling of	42737
Capsulectomy	42719,42722,42731
of finger joints	46336
Capsulotomy, laser	42788
other than laser	42734
Carbolisation of eye	*
Carbon dioxide output, estimation of	11503
Carbuncle, incision and drainage, with GA	30222,30223
Carcinoma	(see tumour)
Cardiac by-pass, whole body perfusion	13603
catheterisation	38200-38218
electrophysiological studies	38209,38212
operation (intrathoracic), other	38456
pacemaker, insertion/replacement	38253
rhythm, restoration, electrical stimulation	13400
surgery, for congenital heart disease	38700-38766
surgery, re-operation via median sternotomy	38640
Cardiopulmonary bypass, cannulation for	38600,38603
Cardiospasm, Heller's operation for	38456
Cardiotocography, antenatal (restriction)	16555
Carotid artery, aneurysm, graft replacement	33100
artery, internal, transection/resection	32703
artery, internal, re-operation, stenosis	32706,33503
body tumour, resection of	34148,34151,34154
cavernous fistula, obliteration of	39815
vessels, examination of	11618,11621,11624
Carpal bone, replacement arthroplasty	46324
ligament, transverse, division of	39331
scaphoid, fracture, treatment of	47354,47357

* Payable on attendance basis

Service	Item
tunnel release	39331
Carpometacarpal joint, arthrodesis of	46303
joint, dislocation, treatment of	47030,47033
joint, synovectomy of	46342
Carpus dislocation, treatment of	47030,47033
fracture, treatment of	47348,47351
operation on, acute osteomyelitis	43503,46462
operation on, chronic osteomyelitis	43512,46462
osteectomy/osteotomy of	48406,48409
Cartilage, tarsal, excision of	42578
Caruncle, urethral, cauterisation of	35523
urethral, excision of	35526,35527
Cataract, juvenile, removal of	42716
Catheter, peritoneal insertion and fixation	13109
Catheterisation, bladder, independent procedure	36800
cardiac	38200-38218
central vein	13318,13815
central vein, subcutaneous tunnel	34527
eustachian tube	41755
frontal sinus	41740
intracranial, for pressure monitoring	13830
peripheral arterial	35318,35321
peripheral venous	35318
peritoneal, for dialysis	13109
right heart balloon flotation	13818
umbilical artery	13303
umbilical or scalp vein in a neonate	13300
ureteric, with cystoscopy	36824
Cauterisation, angioma (restriction applies)	45027
cervix	35608
perforation of tympanum	41641
septum/turbinates/pharynx	41674
tarsus, for ectropian/entropian	42581
urethra or urethral caruncle	35523
Cautery, conjunctiva, including treatment of pannus	42677
nasal, for arrest of haemorrhage	41677
Cavopulmonary shunt, creation of	38733,38736
Cellulitis, incision with drainage, under GA	30222,30223
Central cannulation for cardiopulmonary bypass	38600
nervous system evoked responses	11024,11027
vein catheterisation	13318,13815
vein catheterisation, via subcutaneous tunnel	34527
Cerebello-pontine angle tumour	
- retromastoid removal of	41575,41578
- suboccipital removal	39712
- translabyrinthine removal	41575,41578
- transmastoid removal	41575,41578
Cerebral tumour, craniotomy for removal	39712
ventricle, puncture of	39006
Cerebrospinal fluid drain, lumbar, insertion of	40018
fluid reservoir, insertion of	39018
Cervical discectomy (anterior), without fusion	40333
oesophagectomy	30294
oesophagostomy, closure or plastic repair of	30293
re-exploration for hyperparathyroidism	30317
rib, removal of	34139
sympathectomy	35003,35006
Cervix, amputation or repair of	35617,35618
cauterisation of, other than by chemical means	35608
colposcopic examination of	35614
colposcopy with biopsy and diathermy	35646
cone biopsy of	35617,35618
diathermy of	35608,35646
dilatation of	35621
electrocoagulation diathermy	35644,35645
ionisation of	35608
large loop excision	35647,35648
laser therapy (restriction applies)	35539,35542,35545
purse string ligation for threatened miscarriage	16535,16536
removal of polyp from	35611
removal of purse string ligature, under GA	16539
repair of, not otherwise covered	35617,35618
Chalazion, extirpation of	42575
Chemopallidectomy	40803
Chemotherapy	13915-13936
device for drug delivery, loading of	13939,13942,13945
device, insertion by central vein catheterisation	34527
device, removal of	34530
infusion, cannulation for	34521,34524
Choanal atresia, repair of	43803,43806
Cholangiogram, percutaneous transhepatic	30440
Cholangiography, operative	30439
Cholangiopancreatography	30484
Cholecystectomy	30443-30449
Cholecystoduodenostomy	30460
Cholecystoenterostomy	30460
Cholecystostomy	30375
Choledochoduodenostomy	30461
Choledochoenterostomy	30461
Choledochogastrostomy	30461
Choledochojejunostomy	30460
Choledochoscopy	30442,30452
Choledochotomy	30454,30455,30457
Chondro-cutaneous or chondro-mucosal graft	45656
Chondroplasty of knee	49503,49506
Chordee, correction of	37417
correction for hypospadias/epispadias	37360,37363,37366
penis erection test for	37441
Chorionic villus sampling, inc. associated imaging	16552
Chymopapain (Discase), intradiscal injection of	40336
Cicatricial flexion contracture of joint, correction of	50112
Ciliary body and/or iris, excision of tumour	42767
Circulatory support device, management of	12112,12115
support procedures	38600-38624
Circumcision	30653-30660
arrest of post-operative haemorrhage	
- with GA	30663
- without GA	*
Cisternal puncture	39003
shunt diversion, insertion of	40003
shunt, revision or removal of	40009
Clavicle, dislocation, treatment of	47003,47006
fracture, treatment of	47462,47465
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
osteectomy/osteotomy	48406,48409
Claw toe, correction of	49848
Cleft lip, operations for	45677-45704
palate, correction of	45707,45710,45713
Clitoris, amputation of, medically indicated	35530
Coccyx, excision of	30672
Cochlear implant, insertion with mastoidectomy	41617
tests	11318,11321
Cochleotomy, or repair of round window	41614
Cockett's operation	32524
Coeliac artery, decompression of	34142
Colectomy, subtotal, of large intestine	32004,32005
total	32009-32021
total with excision of rectum	32051,32054,32057
Colles' fracture of radius, treatment of	47369,47372,47375
Colonic lavage, total, intra-operative	32186
Colonoscopy, fibreoptic	32084-32093

*** Payable on attendance basis**

Service	Item
Colorectal strictures, endoscopic dilatation of	32094
Colostomy, closure of	30562
entero-	30515
lavage of	*
refashioning of	30563
with laparotomy	30375
Colotomy, with laparotomy	30375
Colour discrimination test, Farnsworth Munsell	*
Colpoperineorrhaphy	35575-35580
Colpopexy	35590
Colpoplasty	35583,35584
Colposcopy, using Hinselmann-type instrument	35614
with other procedures	35644-35647
Colpotomy	35572
Composite graft to nose, ear or eyelid	45656
Computerised perimetry	11221,11224,11227
Condylectomy	45611,48406,48424
of mandible	45611
Cone biopsy of cervix	35617,35618
Confinement	16506-16520
Congenital absence of vagina, reconstruction for	35565
atresia, auditory canal reconstruction	45662
heart disease, operations for	38700-38766
incontinence, reconstruction of sphincter for	43851
Conjunctiva, cautery of	42677
cryotherapy to	42680
removal of tumour from	(see tumour,other)
Conjunctival cysts, removal of	42683
graft over cornea	42638
lacerations not involving sclera	30032
peritomy	42632
Conjunctivorhinostomy	42629
Consultation	(see attendances)
Contact lenses, attendances	10801-10815
Contour reconstruction, insertion of foreign implant	45051
restoration of face, autologous bone/cartilage graft	45647
Contraceptive device, intra-uterine, introduction of	35503
device, intra-uterine, removal under GA	35506
Contracted bladder neck, congenital, excision/resection	43845
socket, reconstruction	42527
Contracture, cicatricial flexion of joint, correction of	50112
Dupuytren's, subcutaneous fasciotomy for	46366
flexion, of hand or digit, correction of	46492
Cordotomy, laminectomy for	39124
percutaneous	39121
Cornea, conjunctival graft over	42638
epithelial debridement for corneal ulcer/erosion	42650
removal of imbedded foreign body	42644
removal of superficial foreign body	30061
transplantation of	42653,42656,42659
Corneal blood vessels, laser coagulation of	42797
incisions, non penetrating	42674
perforations, sealing of	42635
scars, excision of	42647
sutures, removal of	42668
ulcer, ionisation of	*
ulcer, epithelial debridement of cornea for	42650
Coronary artery bypass operations	38497,38500,38503
Corpus callosum, anterior section of, for epilepsy	40700
Corticectomy, for epilepsy	40703
Corticolysis of lens material	42791
Costo-transverse joint, injection into	39013
Counterpulsation, intra-aortic balloon, management	12106,12109
Cranial nerve, intracranial decompression of	39112
shunt diversion, insertion of	40003
shunt, revision or removal of	40009
vault reconstruction	45785
Craniectomy and removal of haematoma	39603
for osteomyelitis/removal infected bone	39906
Craniocervical junction lesion, transoral approach for	40315
Craniopharyngioma, craniotomy for removal of	39712
Cranioplasty and repair of fractured skull	39615
reconstructive	40600
Craniostenosis, operations for	40115,40118
Craniotomy and tumour removal	39709,39712
burr-hole for intracranial haemorrhage	39600
for arachnoidal cyst	39718
for arteriovenous malformation	39809
for hydromyelia (with laminectomy)	40342
for reopening post-op for haemorrhage/swelling	39721
Cricopharyngeal myotomy	41776
Cryocautery of skin lesions	30189,30192,30195
Cryoneurotomy of peripheral nerves	39323
Cryosurgery to haemorrhoids with rubber band ligation	32135
Cryotherapy for detached retina	42773
for trichiasis	42587
of retina, with vitrectomy	42728
to nose, for haemorrhage	41680
to retina, independent procedure	42818
Curettage, for evacuation of gravid uterus	35643
uterus (D and C)	35639,35640
Cutaneous neoplastic lesions, treatment of	30195
nerve, nerve graft to	39318
nerve, repair of	39300,39303
ureterostomy, closure of	36621
vesical fistula, operation for	37023
vesicostomy, establishment of	37026
Cyclocryotherapy or cyclodiathermy	42770
Cyst, arachnoidal, craniotomy for	39718
Baker's, excision of	30114
Bartholin's, cautery destruction of	35516,35517
Bartholin's, excision of	35512,35513
Bartholin's, marsupialisation of	35516,35517
bone, injection into or aspiration of	47900
brain, operations for	39703
branchial, removal of	30286
breast, aspiration of	*
breast, excision of	30341-30346
broad ligament, excision of	35712-35717
deep, removal of	30143,30144
epididymal, removal of	37600,37601
fimbrial, excision of	35712-35717
hydatid, liver, treatment of	30434,30436,30437
hydatid, lungs, enucleation of	38424
intracranial, needling and drainage of	39703
kidney, removal from	36558
mucous, of mouth, removal	30282,30283
other, removal of	30117-30144
ovarian, excision of, with laparotomy	35712-35717
pancreatic, anastomosis	30586,30587
parovarian, excision of, with laparotomy	35712-35717
pharyngeal, removal of	41813
pilonidal, excision of	30675,30676
renal, excision of	36558
tarsal, extirpation of	42575
thyroglossal, removal of	30313,30314
tooth, removal of (restriction)	30139,30140
vaginal, excision of	35557
vallecular, removal of	41813
Cystic hygroma, removal of	30292
Cystocele, repair of	35575-35580
Cystometrography	11903

* Payable on attendance basis

*** Payable on attendance basis**

Service	Item
Ectopic bladder, 'turning-in' operation	43851
pregnancy, removal of	35676,35677,35678
Ectropion, correction of	45626
tarsal cauterisation for	42581
E.E.G.	11000,11003,11006
Elbow, arthrodesis of	49106
arthroscopic surgery of	49121
arthroscopy of, diagnostic	49118
arthrotomy of	49100
dislocation, treatment of	47018,47021
ligamentous stabilisation of	49103
radial head, replacement of	49112
total replacement of	49115
total synovectomy of	49109
Electrical stimulation, maximal perineal	*
stimulation, restoration cardiac rhythm	13400
Electrocardiography, monitoring during exercise	11712
monitoring of ambulatory patient	11708-11711
signal averaged	11713
twelve lead, report only	11701
twelve lead, tracing only	11702
twelve lead, tracing and report	11700
Electrocochleography, insertion of electrodes for	11303
Electroconvulsive therapy	153
Electrocorticography	11009
Electrode(s), electrocochleography, insertion for	11303
epidural, insertion by laminectomy	39139
epidural, percutaneous insertion of	39130
epidural, percutaneous, management of	39131
intracranial placement	40709,40712
myocardial, permanent, insertion, thoracotomy	38470
pacemaker, permanent, insertion, sub-xyphoid	38473
transvenous, insertion of	38250,38256,38259
Electrodiagnosis, neuromuscular	11012-11021
Electroencephalography (E.E.G)	11000,11003,11006
Electrolysis epilation, for trichiasis	42587
Electromyography (E.M.G.)	11012,11021,11833
Electroneurography of facial nerve	11015
Electronystagmography (E.N.G.)	11339
Electrooculography	11206,11209
Electrophysiological studies, cardiac	38209,38212
Electroretinography	11206,11209
Embolectomy	33803,33806
Embolus, removal from artery of neck	33800
E.M.G.	11012,11021,11833
Empyema, intercostal drainage of	38409,38410
radical operation for	38415
Encephalocoele, excision and closure of	40109
Endarterectomy	33500-33542
to prepare bypass site for anastomosis	33554
Endobronchial tumour, endoscopic laser resection	41901
Endocrine tumour, exploration of	30578,30580,30581
Endolymphatic sac, transmastoid decompression	41590
Endometrium, ablation of, endoscopic	35625
biopsy of	*
biopsy of for suspected malignancy	35624
biopsy of with hysteroscopy	35630
Endoscopic biliary dilatation	30494
cholangio-pancreatography	30484
dilatation of colorectal strictures	32094
examination of intestinal conduit/reservoir	36860
examination of small bowel	30569,32095
gastrostomy, percutaneous	30481,30482
laser resection of endobronchial tumours	41901
laser therapy of gastrointestinal tract	30479
manipulation/extraction of ureteric calculus	36857
prostatectomy	37203
resection of median bar	36854
resection of pharyngeal pouch	41773
sphincterotomy	30485
stenting of bile duct	30491
Endoscopy with balloon dilatation gastric stricture	30475
E.N.G.	11339
Enterocele, repair of	35590,35593
Enterocolostomy	30515
Enterocutaneous fistula, radical repair of	30382
Enteroenterostomy	30515
Enterostomy, closure of	30562
with laparotomy	30375
Enterotomy, intra-operative, for endoscopy	30568
with laparotomy	30375
Entropion, correction of	45626
repair of	42866
Enucleation of eye	42506,42509
hydatid cysts of lung	38424
Epicondylitis, open operation for	47903
Epicutaneous patch testing	12006,12009
Epididymal cyst, excision of	37600,37601
Epididymectomy	37613
Epidural electrode, insertion	39130,39139
electrode, management, adjustment etc.	39131
implant, removal of	39136
stimulator, revision of	39133
Epigastric hernia, repair of	30616-30621
Epilation electrolysis, for trichiasis	42587
Epilepsy, operations for	40700-40712
Epiphyseal arrest	48500-48509
plate, prevention of closure	48512
Epiphysiodesis, femur/fibula/tibia	48500,48503,48506
staple arrest of hemi-epiphysis	48509
Epiphysiolysis, to prevent closure of plate	48512
Epispadias, correction of	37360,37363,37366
Epistaxis, treatment of	41656,41677,41680
Epithelial debridement for corneal ulcer/erosion	42650
Ergometry, with electrocardiography	11712
Erythrocyte radioactive uptake survival time	12503
screening test, volume Cr51	12500
ESWL	36546
Ethmoidal artery, transorbital ligation of	41725
sinuses, operation on	41737,41749
Ethmoidectomy, fronto-nasal	41731
fronto-radical	41734
transantral, with radical antrostomy	41713
Eustachian tube, catheterisation of	41755
Evacuation of products of conception, manual	16564
Evisceration of globe of eye	42512,42515
Evoked response audiometry, brain stem	11300
responses, central nervous system	11024,11027
Exenteration of orbit of eye	42536
Exomphalos, operation for	43833,43836
Exostoses in external auditory meatus, removal	41518
Exostosis, excision of	47933,47936
Extensor tendon of hand or wrist, repair of	46420,46423
tendon of hand, tenolysis of	46450
tendon, synovectomy of	46339
External auditory canal, reconstruction	41524,45662
auditory meatus, removal of exostoses	41518
fixation, orthopaedic, removal	47948,47951
stent, application	34824-34833
Extra digit, amputation of	44103
digit, ligation of pedicle	44100
Extracardiac conduit, insertion/replacement	38757,38760

*** Payable on attendance basis**

Service	Item
Extracorporeal shock wave lithotripsy	36546
Extracranial to intracranial bypass	39818
Extradural tumour or abscess, laminectomy for	40309
Eye, carbolisation of	*
dermoid, excision of	44106,44107,44110
enucleation of	42506,42509
foreign body in, removal of	42560-42569
foreign body in, superficial, removal of	*
foreign body in cornea or sclera, removal of	42644
globe of, evisceration of	42512
paracentesis	42734
trephining of	42746
Eyeball, repair of perforating wound	42551,42554,42557
Eyebrow, elevation of	42872
Eyelashes, ingrowing, operation for	45626
Eyelid closure in facial nerve paralysis, implant insertion	42869
composite graft to	45656
ectropion or entropion, correction of	45626
full thickness laceration, repair of	30052
full thickness wedge excision of	45665
grafting for symblepharon	45629
ptosis, correction of	45623
reconstruction of, whole thickness	45614,45671,45674
reduction of	45617,45620
removal of cyst from	42575
tarsorrhaphy	42584
upper recession of	42863

F

Facet joint denervation by percutaneous neurotomy	39118
Facial, nerve, decompression of	41569
nerve palsy, excision of tissue for	45581
nerve paralysis, plastic operation for	45575,45578
scar, revision of (restriction applies)	45506,45512
Facio-hypoglossal/accessory nerve, anastomosis of	39503
Faecal fistula, abdominal repair of	30381
Fallopian tubes, catheterisation, with hysteroscopy	35633
tubes, hydrotubation of	35703,35709
tubes, implantation of, into uterus	35694,35697
tubes, microsurgical anastomosis	35700
tubes, Rubin test for patency	35703
tubes, sterilisation	35687,35688
tubes, sterilisation with Caesarean section	35691
Family group psychotherapy	154,155,156
group therapy	170,171,172
Farnsworth Munsell colour discrimination test	*
Fascia, deep, repair of, for herniated muscle	30238
graft	45018
tumour, removal of	30153,30156
Fasciectomy, for Dupuytren's Contracture	46369-46393
Fasciotomy, forearm or calf	47975,47978,47981
interosseous muscle space of hand	47981
muscle	30226
plantar, radical	49854
subcutaneous, Dupuytren's contracture	46366
Femoral hernia, repair of	30609,30612,30614
vein puncture in infants, blood collection	13312
vessel, ligation/exploration, other	34103
Femoro-femoral crossover bypass grafting	32718
graft, infected, excision of	34172
Femur, bone graft to	48200,48203
epiphyseodesis	48500,48506
fitting of acrylic head to	49315
fracture, treatment of	47516-47537,49336
operation on, for osteomyelitis	43506,43515
osteectomy/osteotomy	48424,48427
Fenestration cavity, venous graft to	41605
operation	41602
Fibreoptic bronchoscopy	41898
colonoscopy	32084-32093
Fibrinolysis	42791
Fibrinous bands in vitreous body, division of	42764
Fibro-adenoma, excision of from breast	30341-30346
Fibroma, removal of	(see tumour,other)
Fibula, epiphyseodesis	48503,48506
fracture, treatment of	47576
operation on, for osteomyelitis	43503,43512
osteectomy/osteotomy	48406,48409
Field block	(see nerve)
Filtering and allied operations for glaucoma	42746
Fimbrial cyst, removal of	35712-35717
Finger, amputation of	46465-46483
dislocation, treatment of	47036,47039
fracture, treatment of	47300-47333
mallet, fixation/repair	46438,46441
percutaneous tenotomy of	46456
trigger, correction of	46363
Fingernail, ingrowing, excision/resection	47915,47916
Fissure in ano, operation for	32150
Fistula, alimentary, repair of	35596
anal, excision/repair	32159-32166
antrobuccol, operation for	41722
aorto-duodenal, repair of	34160,34163,34166
arteriovenous, dissection, ligation	34112,34115,34118
arteriovenous, dissection, repair	34121-34130
arteriovenous, ligation cervical vessel/s	39812
branchial, removal of	30289
carotid-cavernous, obliteration of	39815
cutaneous, salivary gland, repair of	30269
enterocutaneous, radical resection	30382
faecal, abdominal repair of	30381
genito-urinary, repair	35596
in ano, subcutaneous, excision of	32156
oro-antral, plastic closure of	41722
parotid gland, repair of	30269
sacrococcygeal, excision of	30675,30676
thyroglossal, radical removal of	30314
tracheo-oesophageal, ligation and division	43818
urachal, operation for	43848
urethral, closure of	37312
urethro-rectal	37336
urethro-vaginal	37333
vesical, cutaneous, operation for	37023
vesico-intestinal, closure of	37038
vesico-vaginal, closure of	37029,37032,37035
wound, repair under GA, independent	32168
Fixation, external, removal of	47948,47951
internal, of spine	48678-48690
Flap, Abbe	45701,45704
direct, indirect or local, revision of	45239
indirect	45227-45236
myocutaneous, delay of	45015
myocutaneous, for breast reconstruction	45530
neurovascular island	45563,46504
pharyngeal, for velo-pharyngeal incompetence	45716
repair, direct	45209-45224
repair, local, single stage	45200,45203,45206
repair, muscle, single stage	45000-45012
Flexor tendon, hand, repair of	46426-46435
tendon, hand, tenolysis of	46453
tendon, hand/wrist, synovectomy of	46339

* Payable on attendance basis

* Payable on attendance basis

Service	Item
Glossectomy, with partial pharyngectomy	41785
Goniotomy	42758
Grafenberg's (or Graf) ring, introduction of	35503
ring, removal under GA	35506
Graft, axillo-femoral, infected, excision of	34172
bone	(see bone)
bypass, for occlusive arterial disease	32700-32763
bypass, for treatment of aneurysm	(see aneurysm)
composite (chondro-cutaneous/mucosal)	45656
conjunctival over cornea	42638
corneal	42653,42656,42659
dermis, dermo-fat or fascia	45018
femoro-femoral, infected, excision of	34172
free fascia for facial nerve paralysis	45575,45578
free, skin	45400-45451
inlay, using a mould	45445
micro-arterial or micro-venous	45503
nerve	39315,39318
skin, to orbit	42524
venous, to fenestration cavity	41605
Grafting, bypass, occlusive arterial disease	(see bypass)
bypass, treatment of aneurysm	(see aneurysm)
for symblepharon	45629
patch, to artery or vein	33106,33545,33548
Granuloma, cautery of	42677
removal from eye, surgical excision	42689
Gravid uterus, evacuation of contents by curettage	35643
Great vessel, intrathoracic operation on, other	38456
vessel, ligation or exploration, other	34103
Greater trochanter, transplant of ileopsoas tendon	50121
Groin, lymph, excision of	30329,30330
reoperation for vascular incompetence	32527,32530
Grommet, free, in canal, removal of	*
in situ in drum, removal of	41500
insertion of	41632
Group psychotherapy	154
psychotherapy, family	154,155,156
therapy, family	170,171,172
Gunderson flap operation	42638
Gynaecological examination under GA	35500
Gynatresia, vaginal reconstruction for	35565

H

Haemangioma, cauterisation of (restriction)	45027
of neck, deep-seated, excision of	45036
Haematoma, aspiration of	30216
breast, exploration and drainage	30364
incision and drainage, without GA	30219
large, incision and drainage, with GA	30222,30223
pelvic, drainage of	30387
Haemodialysis, in hospital	13100,13103
Haemofiltration, continuous (ICU)	13833,13836
in hospital	13100,13103
Haemoperfusion, in hospital	13100,13103
Haemorrhage, antepartum, treatment of	16542
arrest of	
- following circumcision, without GA	*
- following circumcision, with GA	30663
- following tonsillectomy, with GA	41796,41797
extremity, reoperation for control of	33848
intracranial, burr-hole craniotomy for	39600
nasal, arrest of	41656,41677
nasal, cryotherapy for treatment of	41680
post-operative, control, perineal/vaginal	30058
post-operative, laparotomy for	30385
postpartum, treatment of	16567
subdural, tap for	39009
Haemorrhoidectomy	32138
Haemorrhoids, injection into	*
removal of	32138
rubber band ligation of	32135
sclerotherapy for	32132
Hair transplants, congenital/traumatic alopecia	45560
Hallux rigidus/valgus, correction of	49821-49842
Halo, application	47711,47714
femoral traction, application of	47720,47723
removal of	47945
thoracic traction, application of	47717
Hammer toe, correction of	49848
Hand, amputation or disarticulation of	44324,44325,44328
arthrotomy	46327,46330
bone grafting for pseudarthrosis	46405
decompression fasciotomy	47981
extensor tendon of, repair of	46420,46423
extensor tendon of, tenolysis of	46450
flexion contracture, correction of	46492
flexor tendon of, repair of	46423-46435
flexor tendon of, tenolysis of	46453
osteectomy/osteotomy	46396,46399
paronychia, pulp space infection incision	47912
tendon sheath, operation for tendovaginitis	46363
tendon transfer for restoration of function	46417
Hare lip	(see cleft lip)
Harrington rods, in treatment of scoliosis or kyphosis	48609
rods, re-exploration for adjustment /removal	48615
Hartmann's operation	32030
Heart arrhythmia, surgery for	38512-38524
catheterisation of	38200,38203,38206
electrical stimulation of	13400
intrathoracic operation on, not otherwise covered	38456
surgery for congenital heart disease	38700-38766
surgery, open, not otherwise covered	38653
valve, repair/replacement	38494
valve replacement	38488,38492
Heller's operation	30532,30533
Hemiarthroplasty of knee	49517
Hemicircumcision, for hypospadias	37354
Hemicolectomy	32006
Hemiepiphysis, staple arrest of	48509
Hemifacial microsomia, construction condyle and ramus	45791
Hemilaryngectomy, vertical, with tracheostomy	41837
Hemispherectomy, for intractible epilepsy	40706
Hemithyroidectomy	30306
Hemivulvectomy	35536
Hepatic duct, common, resection for carcinoma	30463,30464
duct, common, repair of	30472
ducts, Roux-en-Y bypass	30466,30467
Hernia, diaphragmatic, repair of	30600,30601
diaphragmatic, simple closure of	30387
femoral or inguinal, repair of	30609,30612,30614
strangulated, incarcerated or obstructed, repair of	30615
umbilical, epigastric, or linea alba, repair of	30616-30621
ventral or incisional, repair of	30403,30405
Herniated muscle, fascia, deep, repair of	30238
Hiatus hernia, repair of	30601
Hickman catheter, insertion of, for chemotherapy	34527
catheter, removal of	34530
Hindquarter, amputation or disarticulation of	44373
Hinselmann colposcope, examination uterine cervix	35614
Hip, amputation or disarticulation at	44370
arthrectomy	49309,49312

* Payable on attendance basis

* Payable on attendance basis

* Payable on attendance basis

Service	Item
Klockoff's test, assessment of cochlear function changes	11321
Knee, amputation at or below	44367
arthrodesis of	49512,49545
arthroplasty of	49518-49533
arthroscopy of	49557-49566
arthrotomy of	49500
collateral or cruciate ligament repair	49503,49506
dislocation, treatment of	47054
fracture, treatment of	47588,47591
hemiarthroplasty of	49517
ligament or tendon transfer	49503,49506
orthopaedic treatment of	49503,49506
patello-femoral stabilisation	49503,49506
patello-femoral stabilisation, revision of	49548
prosthesis, removal of	49515
repair or reconstruction of	49536,49539,49542
revision of orthopaedic procedures	49551,49554
synovectomy of	49509
Kondoleon operation	30143,30144
Kyphosis, spinal fusion for	48606,48609

L

Labial adhesions, separation of	*
Labioplasty, where medically indicated	35533
Labour, second trimester, management of	16545,16546
Labyrinthotomy, or destruction of labyrinth	41572
Labyrinths, caloric test of	11333,11336
Laceration, nose/ear/eyelid, repair (restriction)	30052
repair and suturing of	30026-30049
Lacrimal canalicular system, establishment patency	42599,42602
canaliculus, immediate repair of	42605
drainage by insertion of glass tube	42608
gland, excision of palpebral lobe	42593
passages, lavage of	42614
passages, obstruction, probing for	42611
sac, excision of	42596
Lagrange's operation (iridectomy and sclerectomy)	42746
Laminectomy and insertion of epidural implant	39139
followed by posterior fusion	40324,40327
for cordotomy or myelotomy	39124
for extradural tumour or abscess	40309
for hydromelia	40342
for intradural lesion	40312
for recurrent disc lesion and/or spinal stenosis	40303
for removal of intervertebral disc/s	40300
for spinal stenosis	40303,40306
with bone graft and posterior fusion	48654,48657
with excision of arteriovenous malformation	40318
with excision of intra-medullary tumour	40318
Laparoscopy and hysteroscopy under GA	35636
complicated operative	35638
diagnostic	30390
involving procedures via laparoscope	35637,35638
sterilisation via	35687,35688
with biopsy	30391
with transection/resection Fallopian tubes	35687,35688
Laparostomy	30397,30399
Laparotomy and division of peritoneal adhesions	30376,30378
exploratory	30373
for control of post-operative haemorrhage	30385,33845
for drainage	30394
for grading of lymphoma	30384
for gross intra-peritoneal sepsis	30396
for neonatal alimentary obstruction	43824
for thrombosis	33845
for trauma, involving 3 or more organs	30388
involving gynaecology (exc. hysterectomy)	35712-35717
involving other op on abdominal viscera	30375,30387
with division of extensive adhesions	30379
with insertion of portacath	30400
Large intestine, resection of	32000,32003
intestine, subtotal colectomy	32004,32005
Laryngectomy	41834
supraglottic	41840
Laryngofissure, external operation on	41876
Laryngopharyngectomy	41843
- or primary restoration of alimentary continuity after	41843
- with tracheostomy and plastic reconstruction	30294
Laryngoplasty	41876,41879
Laryngoscopy	41846,41849,41852
fibreoptic, with examination of larynx	41764
Larynx, direct examination of	41846
direct examination of, with biopsy	41849
direct examination of, with removal of tumour	41852
external operation on	41876
fibreoptic examination of	41764
fractured, operation for	41873
Laser angioplasty, peripheral	35315
beam, application to eyes	42782
photocoagulation	14056-14095
therapy for intraepithelial neoplasia	35539,35542,35545
therapy for malignancy of gastrointestinal tract	30479
Lateral pharyngeal bands, removal of	41804
pharyngotomy	41779
rhinotomy with removal of tumour	41728
Lavage and proof puncture of maxillary antrum	41698,41701
colonic, total, intra-operative	32186
colostomy	*
gastric, in the treatment of ingested poison	14200
lacrimal	42614
maxillary antrum	41704
stomach	*
uterine (saline flushing)	*
Le Fort osteotomies	45753,45754
Lens, artificial, insertion of	42701
artificial, removal or repositioning	42704
artificial, removal and replacement	42707,42710
extraction	42698
intraocular, repositioning of	42713
Lensectomy	42731
Lesion, craniocervical junction, transoral approach for	40315
intradural, laminectomy for, not otherwise covered	40312
Lesions, skin, multiple injections for	30207
Leukoplakia, tongue, diathermy for	*
Leveen shunt, insertion of	30408
Lid, ophthalmic, suturing of	42584
scleral graft to	42860
Ligament, finger joint, repair of	46333
of foot, repair of	49812
or tendon transfer	47966
ruptured medial palpebral, repair of	42854
transplantation	47966
Ligation, great vessel	34103
purse string, cervix, threatened miscarriage	16535,16536
rubber band, of haemorrhoids or rectal prolapse	32135
transantral, of maxillary artery	41707
Ligature of cervix, purse string, removal of	16539
Light coagulation for detached retina	42782
Limb, fasciotomy of	30226
ischaemic, debridement of tissue	35100,35103
lengthening procedures	47939,47942,47943

* Payable on attendance basis

* Payable on attendance basis

Service	Item
Meatoplasty, with correction of auditory canal stenosis	41521
with removal of cartilage and/or bone	41512,41515
Meatotomy and hemi-circumcision, hypospadias	37354
ureteric, with cystoscopy	30265,30266,36830
urethral	37321
Meatus, external auditory, removal of exostoses in	41518
external auditory, removal of keratosis obturans	41509
internal auditory, exploration of	41599
pinhole urinary, dilatation of	37300
Meckel's diverticulum, removal of	30375
Medial palpebral ligament, ruptured, repair of	42854
Median bar, endoscopic resection of	36854
sternotomy for post-operative bleeding	38656
Mediastinum, cervical exploration of	38448
exploration of, for hyperparathyroidism	30318,30320
intrathoracic operation on, not otherwise covered	38456
Meibomian cyst, extirpation of	42575
Melanoma, excision of	(see tumour,other)
Meloplasty, for correction of facial asymmetry	45587
Membranes, retained, intra-uterine manual removal	16564
Meningeal haemorrhage, operations for	39600,39603
Meningocele, excision and closure of	40100
Meniscectomy, knee	49503,49506,49560
temporo-mandibular	45755
Mesenteric artery, inferior, operation on	32736
vessels, by-pass grafting to	32730,32733
Meso caval shunt for portal hypertension	30603
Metacarpal bones, amputation of	44324,44325
bones, bone grafting, pseudarthrosis	46402,46405
bones, fracture, treatment of	47336-47345
bones, operation for osteomyelitis	46462
bones, osteotomy/osteectomy	46396,46399
Metacarpophalangeal joint, arthrodesis	46300
joint, arthroplasty	46306-46321
joint, arthrotomy	46327,46330
joint, dislocation, treatment of	47042,47045
joint, ligamentous repair of	46333
Metacarpus, operation on, for chronic osteomyelitis	43512
Metastatic carcinoma, craniotomy for removal of	39709
Metatarsal bones, osteotomy or osteectomy of	48400,48403
fracture, treatment of	47633-47657
Metatarso-phalangeal joint, synovectomy of	49860,49863
joint, total replacement of	49857
Metatarsus, amputation or disarticulation of	44357,44358
operation on, for chronic osteomyelitis	43500
Microdochotomy of breast, benign or malignant condition	30366
Microlaryngoscopy	41855
- with arytenoidectomy	41867
- with removal of juvenile papillomata	41858
- with removal of papillomata by laser surgery	41861
- with removal of tumour	41864
Microsomia, construction of condyle and ramus	45791
Microvascular anastomosis using microsurgical techniques	45502
repair using microsurgical techniques	45500
Middle ear, clearance of	41635,41638
ear, exploration of	41629
ear, insertion of tube for drainage of	41632
ear, operation for abscess or inflammation of	41626
palmar spaces, drainage of	47909
Midtarsal amputation of foot	44364
Miles' operation	32039
Milroy's disease, operation for	43857,43860
Minnesota tube, insertion of	13827
Miscarriage, habitual, treatment of	16523
incomplete, curettage for	35639,35640
threatened, ligation of cervix	16535,16536
threatened, treatment of	16526
Mitral valve, open valvotomy of	38487
valve stenosis, valvulectomy for	38456
Moh's procedure	31000,31001,31002
Mole, desiccation by diathermy	*
evacuation by manual removal	16564
Molluscum contagiosum, removal in operating theatre	30189
Moschowitz operation	35590
Motility test, manometric, of oesophagus	11800
Mouth, premalignant growth in, removal of	(see tumour,other)
Mucous membrane, biopsy of	30071
membrane, cancer, curettage/cryosurgery	30196-30205
membrane, excision of fold of	(see tumour,other)
membrane, graft	42641
membrane, repair of recent wound	30026-30049
Multiple delivery, administration of anaesthetic	17968
simultaneous injections for varicose veins	32500
Muscle, activity sampling (electromyography)	11012,11015,11018
biopsy of	30074,30075
excision of	30226,30229
extra-ocular, ruptured, repair of	42854
flap, delay of	45015
flap repair	45000,45009,45012
local infiltration in	*
removal of foreign body from	30067,30068
ruptured, repair of	30232,30235
transfer for facial nerve paralysis	45578
transplant (Hummelsheim type), for squint	42848
Myelomeningocele, excision and closure of	40103
Myelotomy, laminectomy for	39124
Myocardial electrode, permanent, insertion, thoracotomy	38470
Myocutaneous flap, delay of	45015
flap repair	45003,45006
Myomectomy, hypertrophic obstructive cardiomyopathy	35649
Myotomy, cricopharyngeal	41770,41776
hypertrophic obstructive cardiomyopathy	38650
ocular muscles	42833,42839,42851
oesophagogastric (Heller's operation)	30532,30533
Myringoplasty	41527,41530
- and ossicular chain reconstruction	41542
- and mastoidectomy	41551,41560
- and revision of mastoidectomy	41566
- with mastoidectomy and ossicular chain recon	41554,41563
Myringotomy	41626

N

Naevus, excision of	(see tumour,other)
Nail bed, exploration and repair of deformity	46489
bed, reconstruction of laceration	46486
digit, ingrowing, excision or resection for	47915,47916,47918
digital, removal of	47904,47906
plate or rod, removal of	47930
Narcotherapy	*
Nasal adhesions, division of	41683
bones, fracture, treatment of	47735,47738,47741
cavity and/or post nasal space, examination of	41653
cavity, packing for arrest of haemorrhage	41677
haemorrhage, arrest of	41656,41677
haemorrhage, cryotherapy in the treatment of	41680
polyp or polypi, removal of	41662,41665,41668
septum, septoplasty or submucous resection	41671
septum button, insertion of	41907
space, post, direct examination of	41761
turbinates, cryotherapy	41695
Nasendoscopy	41764

* Payable on attendance basis

Service	Item
Naso-lacrimal tube, cleaning and replacement without GA	*
tube, replacement of	42611
Nasopharyngeal angiofibroma, transpalatal removal	41767
Nasopharynx, fibreoptic examination of	41764
Neck, deep-seated haemangioma, excision of	45036
excision of infected by-pass graft	34157
lymph glands, excision of	30325,30328
scar, revision of (restriction applies)	45506,45512
Necrosectomy, pancreatic	30577
Necrotic material, debridement of	35100,35103
Needle biopsy, aspiration	*
biopsy of prostate	37218
biopsy of vertebra	30093
Needling of cataract	42734
Neonatal alimentary obstruction, laparotomy for	43824
Neoplasia, intraepithelial, laser therapy	35539,35542,35545
Neoplasms, bladder, diathermy of	37017
Neoplastic lesions, cutaneous, treatment of	30195
Nephrectomy, complete	36515,36516,36519
partial	36522,36525
radical with en bloc dissection of lymph nodes	36528
Nephrolithotomy	36540,36543
Nephropexy, as an independent procedure	36555
Nephroscopy, percutaneous, with	
- destruction and extraction, one or two stones	36639,36642
- incision of renal pelvis/calyx/ureter	36633,36636
- or without stone extract/biopsy/diathermy	36627,36630
- removal/destruction stone>3cm or 3 or more	36645,36648
Nephrostomy	36552
drainage tube, exchange of, imaging guided	36649
percutaneous, including associated imaging	36624
Nephroureterectomy, complete, with bladder repair	36531
Nerve block, regional or field	18206-18298
conduction studies	11012,11015,11018
cranial, intracranial decompression	39112
cutaneous, nerve graft to	39318
cutaneous, primary repair	39300
cutaneous, secondary repair	39303
exploration of	39330
facio-hypoglossal or facio-accessory, anastomosis of	39503
graft to nerve trunk	39315
intracranial, for trigeminal neuralgia	39106
local infiltration around, with alcohol etc	*
peripheral, removal of tumour from	39324,39327
section, translabyrinthine, vestibular	41593
section, retrolabyrinthine, vestibular/cochlear	41596
transposition of	39321
trigeminal, primary branch, injection with alcohol etc	39100
trunk, internal (interfasicular), neurolysis of	39312
trunk, nerve graft to	39315
trunk, primary repair of	39306
trunk, secondary repair of	39309
vestibular, section of, via posterior fossa	39500
Neurectomy, intracranial, for trigeminal neuralgia	39106
peripheral nerve	39324,39327
transantral vidian, with antrostomy	41713
Neuroendocrine tumour, retroperitoneal, removal of	30321,30323
Neurolysis, by open operation	39330
of nerve trunk	39312
Neuroma, acoustic, removal of	39712,41575,41578
Neuromuscular electrodiagnosis	11012-11021
Neurostimulator receiver, spinal, subcutaneous placement	39134
Neurotomy, of peripheral nerves	39327
percutaneous, for facet joint denervation	39118
percutaneous, of spinal nerves	39115
Neurovascular island flap	45563
Nipple, accessory, excision of	30372
inverted, surgical eversion of	30370
reconstruction of	45545
Noble type intestinal plication with enterolysis	30375
Node, lymph, biopsy of	30074,30075
scalene, biopsy	30096
Nodes, lymph, pelvic, excision of	35551
Nodule, treatment, electrosurgical destruction/cryosurgery	*
Non-gravid uterus, suction curettage of	35639,35640
Nose, cauterisation or packing, for haemorrhage	41677
composite graft to	45656
cryotherapy to, for haemorrhage	41680
dermoid of, congenital, excision of	44106,44107,44113
foreign body in, removal of, other than simple	41659
full thickness repair of laceration (restriction)	30052
O	
Obesity, morbid, surgical reversal of gastric procedure	30514
Ocular muscle, torn, repair of	42854
Oculoplethysmography, carotid vessels	11618,11621,11624
Oesophageal motility test, manometric	11800
perforation, repair of, by thoracotomy	30560
prosthesis, insertion of	30490
stricture, endoscopic dilatation of	41819
transection for portal hypertension	30606
tube, indwelling, gastrostomy for fixation	30375
Oesophagectomy	30535-30557
cervical	30294
Oesophagogastric myotomy	30532,30533
Oesophagoscopy	30473-30478
with dilatation of stricture	41819
with rigid oesophagoscope	41816,41822,41825
Oesophagostomy, cervical	30293,30294
closure or plastic repair of	30293
Oesophagus, correction of atresia of	43821
correction of congenital stenosis	43815
dilatation of	41819-41831
intrathoracic operation on, not otherwise covered	38456
local excision for tumour	30559
removal of foreign body in	41825
Olecranon, excision of bursa of	30110,30111
fracture, treatment of	47396,47399,47402
Omentectomy, infra-colic	35726
with debulking operation	35720
Oophorectomy, not associated with hysterectomy	35712-35717
with vaginal hysterectomy	35673
Operative arteriography or venography	35200
cholangiography or pancreatography	30439
procedure not otherwise covered	30000
Ophthalmological examination under GA	42503
Optic fundi, examination of	11212
nerve meninges, incision of	42548
Orbit, anophthalmic, insertion of cartilage or implant	42518
eye, decompression of	42545
eye, exenteration of	42536
eye, exploration of	42530,42533
eye, exploration, removal tumour/foreign body	42539,42542
eye, skin graft to	42524
Orbital cavity, bone or cartilage graft to	45593
cavity, reconstruction of	45590
dermoid, congenital, excision of	44110
dystopia, correction of	45776,45779
implant, enucleation of eye	42506
implant, evisceration of eye and insertion of	42515
implant, integrated, with enucleation of eye	42509

* Payable on attendance basis

* Payable on attendance basis

Service	Item
bone, operation on, for osteomyelitis	43509,43518
bone, osteectomy of	48424,48427
bone, osteotomy of	48427
floor abnormalities, diagnosis of	11830,11833
haematoma, drainage of	30387
lymph glands, excision of	35551,35664,35670
ring, fracture, treatment of	47474-47489
Pelvis, osteotomy or osteectomy of	48424,48427
Penicillin, injection of	*
Penile warts, cystoscopy for treatment of	36815
Penis, amputation of	37402,37405
artificial erection device, insertion	37426,37429
artificial erection device, revision or removal of	37432
circumcision of	30653-30660
correction of chordee	37417
frenuloplasty	37435
injection of	37414
lengthening by translocation of corpora	37423
paraphimosis, reduction of under GA	30666
partial amputation of	37402
repair of avulsion	37411
repair of laceration of cavernous tissue, or fracture	37408
surgery for penile drainage causing impotence	37420
Peptic ulcer, bleeding, control of	30505-30509
ulcer, perforated, suture of	30375
Perchlorate discharge study	12521
Percutaneous aspiration biopsy of deep organ	30094
cordotomy	39121
drainage of deep abscess, imaging guided	30224
endoscopic gastrostomy	30481,30482
epidural electrode, insertion	39130
epidural electrodes, management of	39131
epidural implant, removal	39136
liver biopsy	30409
lumbar discectomy	48636
needle biopsy of lung	38412
neurotomy for facet joint denervation	39118
neurotomy of peripheral nerves	39323
neurotomy of spinal nerves	39115
transhepatic cholangiogram, imaging guided	30440
Perforated duodenal ulcer, suture of	30375
gastric ulcer, suture of	30375
peptic ulcer, suture of	30375
Perforating wound of eyeball, repair of	42551,42554,42557
Perfusion of donor kidney, continuous	13600
of limb or organ	13600
retrograde, intravenous, sympatholytic agent	14209
whole body	13603
Perianal abscess, drainage of	32174,32175
abscess, incision with drainage	30222,30223
tag, removal of, without GA	*
thrombosis, incision of	32147
Pericardectomy	38447,38449
Pericardium, drainage of, sub-xyphoid	38452
drainage of, transthoracic	38450
paracentesis of	38406
Perimetry, quantitative	*
quantitative, computerised	11221,11224,11227
Perineal anoplasty, ano-rectal malformation	43839
biopsy of prostate	37212
operation, for post-operative haemorrhage	30058
prostatectomy	37200
stimulation maximal, electrical	*
stimulation maximal, for stress incontinence	*
Perineorrhaphy	35575,35576
and anterior colporrhaphy	35579,35580
Perinephric abscess, drainage of	36537
area, exploration of	36537
Periorbital correction of Treacher Collins Syndrome	45773
dermoid, congenital, excision of	44106,44107
Doppler examination, carotid vessels	11618,11621,11624
Peripheral arterial atherectomy	35312
arterial catheterisation	35318,35321
cannulation for cardiopulmonary bypass	38603
laser angioplasty	35315
nerve, neurectomy/neurotomy/tumour	39324,39327
venous catheterisation	35318
vessels, examination of	11603-11612
Peritomy, conjunctival	42632
Peritoneal adhesions, division of with laparotomy	30376
biopsies, multiple, with infracolic omentectomy	35726
catheter, insertion and fixation of	13109
dialysis	13112
Peritoneo venous (Leveen) shunt, insertion of	30408
Peritoneoscopy	(see laparoscopy)
Peritonitis, laparotomy for	30394
Peritonsillar abscess, incision of	41807
Periurethral Teflon injection for urinary incontinence	37339
Perurethral resection of contracted bladder neck	43845
Peyronie's plaque, injection for	37414
plaque, operation for	37417
Phalanx, bone grafting of, for pseudarthrosis	46402,46405
distal, for osteomyelitis	46459
finger or thumb, fractures, treatment of	47300-47333
middle or proximal, for osteomyelitis	46462
operation for acute osteomyelitis	43500
operation for chronic osteomyelitis	43512
osteectomy of	46399,48400,48403
osteotomy of	46399,48400,48403
toe, fracture, treatment of	47663-47678
Pharyngeal adhesions, division of	41758
bands or lingual tonsils, removal of	41804
cysts, removal of	41813
flap for velo-pharyngeal incompetence	45716
pouch, endoscopic resection (Dohlman's op)	41773
pouch, removal of	41770
Pharyngectomy, partial	41782,41785
Pharyngoplasty	41786,45716
Pharyngotomy (lateral)	41779
Pharynx, cauterisation or diathermy	41674
removal of foreign body from	30061
Phlebotomy	*
Phonoangiography, carotid vessels	11618,11621,11624
Phonocardiography	11706
Photocoagulation, laser	14056-14095
of xenon arc	42782
Physician, consultant, attendance by	(see attendances)
Pigeon chest, correction of	38457
Pilonidal cyst or sinus, excision of	30675,30676
sinus, injection of sclerosant fluid	30679
Pin, orthopaedic, insertion of	47921
wire or screw, buried, removal of	47924,47927
Pinealoma, craniotomy for removal of	39712
Pinguecula, removal of	42689,42803
Pinhole urinary meatus, dilatation of	37300
Pirogoff's amputation of foot	44361
Pitanguy abdominoplasty	30177
Pituitary tumour, removal of	39715
Placenta, intrauterine manual removal of	16564
ultrasonic localisation by Doppler	*
Placentography, preparation for	36800
Plantar fasciotomy, radical	49854

*** Payable on attendance basis**

* Payable on attendance basis

Service	Item
Q	
Quinsy, incision of	41807
R	
Radial vessel, ligation or exploration, other	34106
Radiation dosimetry	15518-15536
field setting	15500-15515
oncology treatment	15203-15214
Radioactive B12 absorption test	12512,12515
Radioisotope, therapeutic dose, administration of	16000-16012
Radiotherapy, deep or orthovoltage	15100-15115
planning	15500-15536
radioactive sources, sealed	15303-15357
radioactive sources, unsealed	16000-16012
superficial	15000-15012
Radioulnar joint, dislocation, treatment of	47024,47027
joint, distal, reconstruction	46345
joint, distal, synovectomy	46342
Radius, and ulna, bone graft to	48221
bone graft to	48218
fracture, treatment of	47360-47408
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
or ulna, bone graft to	48224,48227
osteectomy of	48406
osteotomy of	48406,48409
Ramstedt's pyloromyotomy	30632
Ranula, removal of	30282,30283
Rectal biopsy, full thickness	32096
fistula, closure of	37038,37336
polyp, removal of with sigmoidoscopy	32078,32081
prolapse, Delorme procedure for	32111
prolapse, reduction of	*
prolapse, repair of	32117,32120
prolapse, rubber band ligation of	32135
prolapse, sclerotherapy for	32132
stricture, per anal release of	32114
tumour, excision of	32099,32102,32108
Rectocele, repair of	35575-35580
Rectoplasty, ano-rectal malformation	43842
Rectosigmoidectomy (Hartmann's operation)	32030
for Hirschsprung's disease	43830
Rectosphincteric reflex, measurement of	11830
Rectovaginal fistula, repair of	35596
Rectum and anus, abdomino-perineal resection of	32039-32048
anterior resection of	32024,32027
perineal resection of	32047
suction biopsy of	30071
Recurrent hernia, repair of	30403
sapheno-femoral incompetence, operation	32530
sapheno-popliteal incompetence, operation	32527,32530
Reduction ureteroplasty	36618
Refitting of contact lenses	10815
Reflux, vesico-ureteric, correction of	36588
Refractive keratoplasty	42671
Regional nerve block	(see nerve)
Regitine phentolamine test for phaeochromocytoma	*
Renal artery, aberrant, operation for	36537
biopsy (closed)	36561
cyst, excision of	36558
dialysis in hospital	13100,13103
function test	12524,12527
pelvis, brush biopsy of, with cystoscopy	36821
transplant	36503,36506,36509
Respiratory function, estimation of	11503-11512
Resuturing of surgical wounds (not burst abdomen)	*
of wound following intraocular procedures	42857
Retina, cryotherapy of	42728,42818
detached, diathermy or cryotherapy for	42773
detached, removal of encircling silicone band	42812
detached, resection or buckling operation for	42776
detached, revision operation for	42779
light coagulation for	42782
photocoagulation of	42809
pre-detachment of, cryotherapy for	42818
Retinal photography	11215,11218
Retrobulbar abscess, operation for	42572
injection of alcohol	42824
transillumination	42821
Retrolabyrinthine vestibular nerve section	41596
Retroperitoneal abscess, drainage of	30402
lymph node biopsies	35723
lymph node dissection	37607,37610
neuroendocrine tumour, removal of	30321,30323
Retropharyngeal abscess, incision with drainage	30222,30223
Retropubic prostatectomy	37200
Retroversion, operation for	35683,35684
Rhinophyma, shaving of	45653
Rhinoplasty procedures	45632-45644
secondary revision of	45650
Rhinotomy, lateral, with removal of tumour	41728
Rhizolysis, spinal	40330
Rib, cervical, removal of	34139
first, resection of portion	34136
fracture, treatment of	47471
operation for acute osteomyelitis	43503
operation for chronic osteomyelitis	43512
osteectomy of	48406,48409
osteotomy of	48406,48409
resection, with radical operation for empyema	38415
Rod, plate or nail, removal of	47930
Rodent ulcer, operation for	(see tumour,other)
Rosen incision, myringoplasty	41527
Rotator cuff of shoulder, repair of	48906,48909
Round window repair or cochleotomy	41614
Roux-en-Y biliary bypass	30460,30466,30467
Rovsing's operation	36537
Rubin test for patency of Fallopian tubes	35706
Ruptured medial palpebral ligament, repair of	42854
membranes, threatened premature labour	16532
muscle, repair of	30232,30235
thoracic aorta, operative management of	38572
urethra, repair of	37306,37309
viscus, major repair or removal of	30375
S	
Sacral sinus, excision of	30675,30676
Sacrococcygeal and presacral tumour, excision of	32036
Sacroiliac joint, arthrodesis of	49300
joint, disruption of	47513
Salivary gland, major, transposition of duct	41910
gland, operations on	30262-30269
Salpingectomy not associated with hysterectomy	35712-35717
with vaginal hysterectomy	35673
Salpingo-oophorectomy not with hysterectomy	35712-35717
Salpingolysis	35694,35697
Salpingostomy	35694,35697
Sapheno-femoral incompetence, re-operation for	32530
Sapheno-popliteal incompetence, re-operation for	32527,32530

* Payable on attendance basis

Service	Item
Saphenous vein anastomosis	34809
vein, long, complete dissection and ligation	32512
Scalene node biopsy	30096
Scalenotomy	34133
Scalp vein catheterisation in a neonate	13300
Scaphoid, bone graft to	48230,48233,48236
Scapula, fracture, treatment of	47468
operation for chronic osteomyelitis	43512
(other than acromion), osteectomy of	48406,48409
(other than acromion), osteotomy of	48406,48409
Scar, abrasive therapy to	45021,45024
face or neck, revision of (restriction applies)	45506,45512
other than face or neck, revision of (restriction)	45515,45518
removal of, not otherwise covered	(see tumour,other)
Scars, corneal, removal of, by partial keratectomy	42647
Schilling test	12512,12515
Sclera, removal of imbedded foreign body	42644
removal of superficial foreign body	30061
transplantation of	42662
transplantation of, superficial or lamellar	42665
Scleral blood vessels, laser coagulations of	42797
graft to lid	42860
Sclerectomy and iridectomy for glaucoma	42746
Sclerosant fluid, injection of into pilonidal sinus	30679
injection of starburst vessels, head/neck	30213
injection of telangiectases, head/neck	30213
Scoliosis, anterior correction of (Dwyer procedure)	48621,48624
congenital, vertebral resection and fusion for	48632
re-exploration for	48615
requiring anterior decompression of spinal cord	48630
revision of failed scoliosis surgery	48618
spinal fusion for	48606,48609,48612
spinal fusion for, with segmental instrumentation	48627
spinal fusion with use of Harrington rod	48681
Screw, pin or wire, buried, removal of	47924,47927
Scrotal contents, exploration of	37604
Scrotum, excision of abscess of	30222,30223
partial excision of	37438
Sebaceous cyst, removal of	(see tumour,other)
Second trimester labour, management of	16545,16546
Secondary, repair of extensor tendon of hand or wrist	46423
repair of flexor tendon of hand or wrist	46429
Segmentectomy	38438
Selective coronary arteriography, preparation	38215,38218
Semimembranosus bursa, excision of	30114
Sengstaken-Blakemore tube, insertion of	13827
Septal perforation, closure of	41671
Septoplasty of nasal septum	41671
Septum button, nasal, insertion of	41907
cauterisation or diathermy of	41674
nasal, septoplasty or submucous resection	41671
vaginal, excision of, for correction of double vagina	35566
Sequestrectomy	43512-43524
Seroma, breast, exploration, drainage, operating theatre	30364
Sesamoid bone, osteotomy or osteectomy of	48400
Seton, readjustment of, in anal fistula	32166
Shirodkar suture	16535,16536
Shoulder, amputation or disarticulation at	44331
arthrectomy or arthrodesis	48939,48942
arthroscopic surgery	48948-48960
arthroscopy	48945
arthrotomy	48912
dislocation, treatment of	47009,47012,47015
hemi-arthroplasty of	48915
orthopeadic treatment of	48900,48903
prosthesis, removal of	48927
removal of calcium deposit from cuff	48900
rotator cuff, repair of	48906,48909
spica, application of	47540
stabilisation, anterior, for recurrent dislocation	48930
stabilisation, for multidirection instability	48933
synovectomy of	48936
total replacement of	48918,48921,48924
Shunt, arteriovenous, external, insertion/removal	34500,34506
cranial or cisternal, insertion of	40003
cranial or cisternal, revision or removal of	40009
lumbar, insertion of	40006
lumbar, revision or removal of	40009
Sigmoidoscopic examination	32072,32075
- with diathermy or resection of polyp/s	32078,32081
Sigmoidoscopy, fibreoptic, flexible	32084,32087
Silicone band, encircling, removal from detached retina	42812
Sinoscopy	41764
Sinus, diathermy of	*
ethmoidal, external operation on	41749
excision of	30099,30102,30103
frontal, catheterisation of	41740
frontal, radical obliteration of	41746
frontal, trephine of	41743
injection of sclerosant fluid under anaesthesia	30679
intranasal operation on	41737
maxillary, drainage of, through tooth socket	41719
pilonidal, excision of	30675,30676
sphenoidal, intranasal operation on	41752
urogenital, vaginal reconstruction for	35565
Skin, biopsy of	30071
cancer, treatment of	30196-30205
graft to orbit	42524
grafts	(see graft)
lesions, multiple injections for	30207
lesions, treatment of	30192,30195
malignant tumour, removal of	30147,30150
repair of recent wound of	30026-30049
sensitivity testing for allergens	12000,12003
tags, anal, excision of	32142,32145
Skull base tumour, removal, infra-temporal	41581
calipers, insertion of	47705
fracture, attendance for treatment of	47703
fractured, operations for	39606-39615
osteomyelitis, acute, operation for	43503
osteomyelitis, chronic, operation for	43521
osteomyelitis, craniectomy for	39906
treatment of fracture, not requiring operation	47703
tumour, excision of	39700
Sleep apnoea, overnight investigation for	12203,12206
Sling operation for stress incontinence	35599
procedure, intestinal, prior to radiotherapy	32183
Slough, debridement of	35100,35103
Small bone, exostosis, excision of	47933
bowel intubation	30487,30488
bowel, endoscopic examination of	32095
intestine, resection of	30565,30566
Smith's fracture of radius, treatment of	47369,47372,47375
Smith-Petersen nail, removal of	47924,47927
Socket, eye, contracted, reconstruction of	42527
Specialist attendance	(see attendance)
Specimen of sweat, collection of, by iontophoresis	12200
Speech discrimination tests	11321
Spermatic cord, exploration of, inguinal approach	30644
Spermatocele, excision of	37600,37601
Sphenoidal sinus, intranasal operation on	41752
Sphincter, anal, direct repair of	32129

* Payable on attendance basis

*** Payable on attendance basis**

*** Payable on attendance basis**

U

* Payable on attendance basis

Service	Item
Ulna, and radius, bone graft to	48221
bone graft to	48218
fracture, treatment of	47360-47408
operation on, for acute osteomyelitis	43503
operation on, for chronic osteomyelitis	43512
or radius, bone graft to	48224,48227
osteectomy of	48406
osteotomy of	48406,48409
Ulnar vessel, ligation/exploration not otherwise covered	34106
Ultrasonic localisation of placenta, Doppler technique	*
Ultrasound, intraoperative	30439
Umbilical artery catheterisation	13303
hernia, repair of	30616-30621
vein catheterisation in a neonate	13300
Undescended testis, transplantation of	30647
Unstable lie, attendances other than routine antenatal	16529
Urachal fistula, operation for	43848
Ureter, brush biopsy of, with cystoscopy	36821
divided, repair of	36573
exploration of	36612
retrocaval, correction of, by open exposure	36564,36567
transplantation of	
- into another ureter	36597
- into bladder	36588,36591
- into bowel	36582
- into intestine	36594
- into isolated intestinal segment	36600,36603
- into skin	36585
Ureterectomy	36579
Ureteric calculus, endoscopic extraction/manipulation	36857
catheterisation with cystoscopy	36818,36824
dilatation	36821
meatotomy	36830
reflux, correction of	36588
stent, insertion of	36821
Ureterolithotomy	36549
complicated by previous surgery	37444
Ureterolysis	36615
Ureteroplasty	36618
Ureteroscopy	36803,36806,36809
Ureterostomy, cutaneous, closure of	36621
revision of	36609
Urethra, cauterisation of	35523
correction of male urinary incontinence	37378
diathermy of	37318
endoscopic examination with cystoscopy	36812
laser therapy, intraepithelial neoplasia	35539,35542,35545
prolapsed, excision of	35587,37369
ruptured, repair of	37306,37309
Urethral abscess, drainage of	30222,30223
caruncle, cauterisation of	35523
caruncle, excision of	35526,35527
dilatation with cystoscopy	36812
diverticulum, excision of	37372
fistula, closure of	37312,37333,37336
pressure profilometry	11906,11909
reconstruction, hypospadias/epispadias	37360,37363,37366
sounds, passage of, as an independent procedure	37300
sphincter, reconstruction of	37375
stricture, dilatation of	37303
stricture, optical urethrotomy for	37327
stricture, plastic repair of	37342-37351
tumour, removal of by urethrectomy	37330
valves, destruction of	37399
valves, open removal of	43854
warts, cystoscopy for the treatment of	36815
Urethrectomy	37330
Urethrocele, operation for	35587
Urethropexy (Marshall-Marchetti operation)	35599,37044
Urethroplasty	37342-37351
Urethroscopy, as an independent procedure	37315
with biopsy/diathermy/foreign body/stone	37318
with cystoscopy	36812
with cystoscopy and Teflon injection	37339
Urethrostomy	37324
Urethrotomy, external or internal	37324
optical, for urethral stricture	37327
Urinary conduit or reservoir, endoscopic examination	36860
conduit, revision of	36609
infection, bladder washout test	11921
reservoir, formation of	36606
sphincter, artificial	
- insertion of cuff	37381,37384
- insertion of pressure regulating balloon, pump	37387
- revision or removal of	37390
Urine flow study	11900
Urogenital sinus, vaginal reconstruction for	35565
Uterine adenomyoma, excision of	35649
adhesiolysis, with hysteroscopy	35633
adnexae, removal, with abdominal hysterectomy	35653
lavage, (saline flushing)	*
tubes, insufflation of, for patency (Rubin test)	35706
Uterus, bicornuate, plastic reconstruction for	35680
curettage of	35639,35640
gravid, evacuation of contents	35643
implantation of Fallopian tubes into	35694,35697
manipulative correction of acute inversion of	16570
suspension or fixation of	35683,35684
UVB therapy	14050,14053
Uvula, excision of	41810
Uvulotomy	41810

V

Vacuum extraction delivery, anaesthetic for	17968
Vagina, artificial formation of	35565
dilatation of, as an independent procedure	35554
laser therapy, intraepithelial neoplasia	35539,35542,35545
partial or complete removal of	35560
removal of simple tumour of	35557
Vaginal fistula, repair or closure of	35596,37029,37333
hysterectomy	35657,35673
operation, control of post-operative haemorrhage	30058
orifice, plastic repair to enlarge	35569
reconstruction, congenital absence/gynatresia	35565
repair	35567
repair, anterior and/or posterior	35575-35580
septum, excision for correction of double vagina	35566
vault, suspension of, abdominal approach	35590
warts, removal under GA or nerve block	35507,35508
Vaginectomy, radical, for malignancy	35561,35562,35564
Vagotomy	30496-30503
Vallecular cysts, removal of	41813
Valve, aortic, decalcification of	38486
mitral, open valvotomy of	38487
repair, heart	38494
replacement, heart	38488,38492
Valves, heart, operations on	38488,38492,38494
urethral, operation for congenital abnormalities	43854
Valvotomy, open, of mitral valve	38487
Valvulotomy for pulmonary stenosis	38456
Varicocele, surgical correction of	30634,30635

* Payable on attendance basis

*** Payable on attendance basis**

ORAL AND MAXILLOFACIAL SERVICES BY APPROVED DENTAL PRACTITIONERS

CATEGORY 4

PLEASE NOTE:

The information contained in this Category relates specifically to the Medicare Arrangements relating to Services by Approved Dental Practitioners. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the FOREWORD and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category. (The arrangements set out in the FOREWORD and GENERAL EXPLANATORY NOTES apply equally to Approved Dental Practitioners)

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES
(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

EXPLANATORY NOTES

SCHEDULE OF SERVICES

INDEX

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES
(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

OA. INTRODUCTION

OA.1 Benefits for Medical Services by Dental Practitioners
Under the provisions of the Health Insurance Act 1973 (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by an approved dental practitioner. Approved dental practitioners may also request certain diagnostic imaging services (see para DIA.4.8 of the Category 5 Explanatory Notes).

Details of the services attracting Medicare benefits are set out in the Schedule following these explanatory notes.

OB. APPROVAL OF DENTAL PRACTITIONERS (ORAL SURGEONS)

OB.1 Application for Approval
State registered dentists practising in the specialty of oral surgery may apply to the Medical Benefits (Dental Practitioners) Advisory Committee for the purposes of Subsection 3(1) of the Act for approval to carry out prescribed medical services (oral surgery). When these practitioners are approved they may perform those items of oral surgery listed in this Category. All dental practitioners approved for the purposes of Subsection 3(1) of the Act are also recognised to perform those items of oral surgery listed in Group C2 of the booklet "Medicare Benefits for the Treatment of Cleft Lip and Cleft Palate Conditions".

A Medical Benefits (Dental Practitioners) Advisory Committee considers applications lodged by dental practitioners and recommends to the Minister the names of those dental practitioners who, in its opinion, should be approved by the Minister for the purposes of Subsection 3(1) of the Act.

The Committee is composed of dental practitioners nominated by the Australian Dental Association.
The main criteria for granting approval for the purposes of the Act are that the dental practitioner should be either -

- a State registered oral surgeon who is engaged in the referred practice of oral surgery; or
- a dental practitioner who can substantiate, by experience, or hospital or teaching appointments, a competence in the field of oral surgery.

Practitioners who consider that they meet the criteria set out in the preceding paragraph and who wish to be considered for approval for the purposes of Subsection 3(1) of the Act should write to the Department of Health, Housing, Local Government and Community Services, GPO Box 9848, Canberra ACT 2601 for an application form.

Advice concerning the names and addresses of practitioners who have been approved for the purposes of Subsection 3(1) of the Act may be obtained from the local office of the Health Insurance Commission (see para 1.3 of the General Explanatory Notes to this book for addresses); or from the local State Branch of the Australian Dental Association.

It is emphasised that -

(i) the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;
(ii) the services set out in Groups 01 to 09 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

OB.2 Right of Appeal for Dental Practitioners Not Approved
Where the Minister decides that a dental practitioner should not be approved as an oral surgeon, the dental practitioner may appeal to the Medical Benefits (Dental Practitioners) Appeals Committee, which is composed of dental practitioners who are not on the Advisory Committee. The application should be made to the Department of Health, Housing, Local Government and Community Services, GPO Box 9848, Canberra ACT 2601.

EXPLANATORY NOTES

OC. INTERPRETATION OF THE SCHEDULE

OC.1 Principles of Interpretation
Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

OC.2 Multiple Operation Rule

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

100% for the item with the greatest Schedule fee, plus 50% for the item with the next greatest Schedule fee, plus 25% for each other item.

NOTE:
1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents
2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups O3 to O9.

If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

OC.3 After-care

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner.

This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation. Cases which are considered to come under this heading should be referred to the local Medicare office for consideration.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item 52057 is a service to which this policy applies.

OC.4 Administration of Anaesthetics by Medical Practitioners

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

Medicare benefits are also payable for the services of one assistant anaesthetist (a medical practitioner) where the procedure has an anaesthetic unit value of not less than 21 units.

Before Medicare benefits will be paid for the administration of an anaesthetic, or for the services of an assistant anaesthetist, the name of the practitioner who rendered the procedure must be shown on the account.

The Schedule fee and benefits payable for the administration of an anaesthetic in connection with a particular medical service are determined according to the number of anaesthetic units allocated to each procedure likely to be performed under anaesthesia. The number of units appropriate for each procedure is shown after the description of the procedure.

To ascertain the Schedule fee from the number of anaesthetic units so determined, medical practitioners should refer to Group T6 of Category 3 of this Book.

OC.5 Assistance at Operations (51800, 51803)

The benefit for assistance at an operation varies according to the Schedule fee for the operation.

Medicare benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a practitioner other than the anaesthetist or assistant anaesthetist.

The amount of benefit specified for assistance at an operation is the amount payable whether the assistance is rendered by one or more than one practitioner.

OC.6 Operations

Osteotomy of Jaw (Items 52342 - 52375)

The fees and benefits for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g.

iliac crest, would attract additional benefit under Item 52318 in accordance with the multiple operation rule.

For the purposes of these items, a reference to maxilla includes the zygoma.

Genioplasty (Item 52378)
Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

Fracture of Mandible or Maxilla (Items 53400 - 53439)
There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones. Hence a bilateral fracture of the mandible would be assessed as, say Item 53409 x 1½; two maxillae and one side of the mandible as Item 53406 x 1½ + 53409 x ¼.

Splinting in Item 53406 or 53409 refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

GROUP O1 - CONSULTATIONS

51700	PROFESSIONAL ATTENDANCE (other than a second or subsequent attendance in a single course of treatment) BY AN APPROVED DENTAL PRACTITIONER where the patient is referred to him/her - an attendance related to a subsequent operative procedure described in an item in Groups O3 to O9 where that attendance is at consulting rooms, hospital or nursing home **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
51703	PROFESSIONAL ATTENDANCE BY AN APPROVED DENTAL PRACTITIONER where the patient is referred to him/her - each attendance related to an operative procedure described in an item in Groups O3 to O9 subsequent to the first in a single course of treatment where that attendance is at consulting rooms, hospital or nursing home **Fee:** $30.55 **Benefit:** 75% = $22.95 85% = $26.00

GROUP O2 - ASSISTANCE AT OPERATION

51800	ASSISTANCE by an APPROVED DENTAL PRACTITIONER at any operation for which the fee exceeds $180.90 but does not exceed $321.35 or at a series or a combination of operations where the fee for at least 1 of the operations exceeds $180.90 but where the fee for the series or combination of operations does not exceed $321.35 *(See para OC. of explanatory notes to this Category)* **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
51803	ASSISTANCE by an APPROVED DENTAL PRACTITIONER at any operation for which the fee exceeds $321.35 or at a combination of operations for which the aggregate fee exceeds $321.35 provided that the fee for at least 1 of the operations exceeds $180.90 *(See para OC. of explanatory notes to this Category)* **Derived Fee:** one fifth of the established fee for the operation or combination of operations

GROUP O3 - GENERAL SURGERY

52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CENTIMETRES LONG), superficial (AU 7 - 17907) **Fee:** $58.90 **Benefit:** 75% = $44.20 85% = $50.10
52001	OPERATIVE PROCEDURE ON TISSUE, ORGAN OR REGION not being a service to which another item in Groups O3 to O9 applies, including any consultation on the same occasion **Fee:** $5.15 **Benefit:** 75% = $3.90 85% = $4.40
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CENTIMETRES LONG), involving deeper tissue (AU 7 - 17907) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CENTIMETRES LONG), superficial (AU 7 - 17907) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CENTIMETRES LONG), involving deeper tissue (AU 8 - 17908) **Fee:** $132.85 **Benefit:** 75% = $99.65 85% = $112.95
52012	SUPERFICIAL FOREIGN BODY, removal of, as an independent procedure (AU 5 - 17905) **Fee:** $16.70 **Benefit:** 75% = $12.55 85% = $14.20
52015	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and suture, as an independent procedure (AU 6 - 17906) **Fee:** $78.20 **Benefit:** 75% = $58.65 85% = $66.50
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (AU 7 - 17907) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (AU 6 - 17906) **Fee:** $21.00 **Benefit:** 75% = $15.75 85% = $17.85
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (AU 5 - 17905) **Fee:** $37.25 **Benefit:** 75% = $27.95 85% = $31.70
52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure (AU 6 - 17906) **Fee:** $107.10 **Benefit:** 75% = $80.35 85% = $91.05
52030	SINUS, excision of, involving superficial tissue only (AU 6 - 17906) **Fee:** $64.25 **Benefit:** 75% = $48.20 85% = $54.65
52033	SINUS, excision of, involving muscle and deep tissue (AU 7 - 17907) **Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (AU 6 - 17906) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), up to 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (AU 9 - 17909) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), more than 3 centimetres in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (AU 6 - 17906) **Fee:** $122.10 **Benefit:** 75% = $91.60 85% = $103.80

52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (AU 8 - 17908) **Fee:** $175.65 **Benefit:** 75% = $131.75 85% = $149.35
52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (AU 8 - 17908) **Fee:** $262.45 **Benefit:** 75% = $196.85 85% = $234.75
52051	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (AU 8 - 17908) **Fee:** $358.85 **Benefit:** 75% = $269.15 85% = $331.15
52054	TUMOUR, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (AU 10 - 17910) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
52055	HAEMATOMA, ABSCESS OR CELLULITIS not requiring a general anaesthesia, incision with drainage of (excluding after-care) **Fee:** $19.45 **Benefit:** 75% = $14.60 85% = $16.55
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, INCISION WITH DRAINAGE OF (excluding after-care), where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 5 - 17905) **Fee:** $115.70 **Benefit:** 75% = $86.80 85% = $98.35
52060	MUSCLE, excision of (AU 6 - 17906) **Fee:** $134.95 **Benefit:** 75% = $101.25 85% = $114.75
52063	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (AU 7 - 17907) **Fee:** $251.75 **Benefit:** 75% = $188.85 85% = $224.05
52066	SUBMANDIBULAR GLAND, extirpation of (AU 8 - 17908) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30
52069	SUBLINGUAL GLAND, extirpation of (AU 7 - 17907) **Fee:** $141.40 **Benefit:** 75% = $106.05 85% = $120.20
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (AU 6 - 17906) **Fee:** $41.80 **Benefit:** 75% = $31.35 85% = $35.55
52075	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures (AU 7 - 17907) **Fee:** $107.10 **Benefit:** 75% = $80.35 85% = $91.05
52078	TONGUE, partial excision of (AU 7 - 17907) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $182.30
52081	TONGUE TIE, division or excision of frenulum (AU 6 - 17906) **Fee:** $33.20 **Benefit:** 75% = $24.90 85% = $28.25
52084	TONGUE TIE, MANDIBULAR FRENULUM OR MAXILLARY FRENULUM, division or excision of frenulum, in a person aged not less than 2 years (AU 6 - 17906) **Fee:** $84.60 **Benefit:** 75% = $63.45 85% = $71.95
52087	RANULA OR MUCOUS CYST OF MOUTH, removal of (AU 9 - 17909) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
52090	OPERATION ON MANDIBLE OR MAXILLA (other than alveolar margins) for osteomyelitis - 1 bone (AU 10 - 17910) **Fee:** $253.40 **Benefit:** 75% = $190.05 85% = $225.70

52092	OPERATION on SKULL for OSTEOMYELITIS (AU 12 - 17912) **Fee:** $330.95 **Benefit:** 75% = $248.25 85% = $303.25
52096	ORTHOPAEDIC PIN OR WIRE, insertion of, into maxilla or mandible or zygoma, as an independent procedure (AU 5 - 17905) **Fee:** $80.65 **Benefit:** 75% = $60.50 85% = $68.60
52099	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52102 or 52105 applies (AU 6 - 17906) **Fee:** $100.30 **Benefit:** 75% = $75.25 85% = $85.30
52102	BURIED WIRE, PIN or SCREW, 1 or more, which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, where undertaken in the operating theatre of a hospital or approved day-hospital facility, per bone (AU 6 - 17906) **Fee:** $100.30 **Benefit:** 75% = $75.25 85% = $85.30
52105	PLATE, 1 or more of, and associated screw and wire which were inserted for internal fixation purposes into maxilla or mandible or zygoma, removal of, requiring anaesthesia, incision, dissection and suturing, per bone, not being a service associated with a service to which item 52099 or 52102 applies (AU 6 - 17906) **Fee:** $188.25 **Benefit:** 75% = $141.20 85% = $160.55
52108	LIP, full thickness wedge excision of, with repair by direct sutures (AU 8 - 17908) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
52111	VERMILIONECTOMY (AU 8 - 17908) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
52114	MANDIBLE or MAXILLA, segmental resection of, for tumours or cysts (AU 13 - 17913) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (AU 13 - 17913) **Fee:** $496.45 **Benefit:** 75% = $372.35 85% = $468.75
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (AU 29 - 17929) **Fee:** $589.15 **Benefit:** 75% = $441.90 85% = $561.45
52122	MANDIBLE, HEMI-MANDIBULAR RECONSTRUCTION with BONE GRAFT, not being a service associated with a service to which item 52123 applies (AU 15 - 17915) **Fee:** $589.50 **Benefit:** 75% = $442.15 85% = $561.80
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (AU 35 - 17935) **Fee:** $667.10 **Benefit:** 75% = $500.35 85% = $639.40
52126	MAXILLA, total resection of (AU 25 - 17925) **Fee:** $642.70 **Benefit:** 75% = $482.05 85% = $615.00
52129	MAXILLA, total resection of both maxillae (AU 30 - 17930) **Fee:** $856.95 **Benefit:** 75% = $642.75 85% = $829.25
52132	TRACHEOSTOMY (AU 10 - 17910) **Fee:** $169.25 **Benefit:** 75% = $126.95 85% = $143.90
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital or approved day-hospital facility (AU 7 - 17907) **Fee:** $102.85 **Benefit:** 75% = $77.15 85% = $87.45
52138	MAXILLARY ARTERY, ligation of (AU 12 - 17912) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (AU 12 - 17912) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30

52144	FOREIGN BODY, deep, removal of using interventional imaging techniques (AU 10 - 17910) **Fee:** $294.55 **Benefit:** 75% = $220.95 85% = $266.85
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (AU 16 - 17916) **Fee:** $278.50 **Benefit:** 75% = $208.90 85% = $250.80
52148	PAROTID DUCT, repair of, using micro-surgical techniques (AU 14 - 17914) **Fee:** $491.25 **Benefit:** 75% = $368.45 85% = $463.55

GROUP O4 - PLASTIC & RECONSTRUCTIVE

52300	SINGLE STAGE LOCAL FLAP, where indicated, repair to 1 defect, with skin or mucosa (AU 7 - 17907) **Fee:** $203.50 **Benefit:** 75% = $152.65 85% = $175.80
52303	SINGLE STAGE LOCAL FLAP, where indicated, repair to 1 defect, with buccal pad of fat (AU 10 - 17910) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
52306	SINGLE STAGE LOCAL FLAP, where indicated, repair to 1 defect, using temporalis muscle (AU 10 - 17910) **Fee:** $429.20 **Benefit:** 75% = $321.90 85% = $401.50
52309	FREE GRAFTING (mucosa or split skin) of a granulating area (AU 7 - 17907) **Fee:** $145.70 **Benefit:** 75% = $109.30 85% = $123.85
52312	FREE GRAFTING (mucosa or split skin) to 1 defect, including elective dissection (AU 8 - 17908) **Fee:** $203.50 **Benefit:** 75% = $152.65 85% = $175.80
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) (AU 9 - 17909) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (AU 7 - 17907) **Fee:** $100.30 **Benefit:** 75% = $75.25 85% = $85.30
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (AU 7 - 17907) **Fee:** $167.55 **Benefit:** 75% = $125.70 85% = $142.45
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (AU 10 - 17910) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
52324	DIRECT FLAP REPAIR, using tongue, first stage (AU 7 - 17907) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
52327	DIRECT FLAP REPAIR, using tongue, second stage (AU 7 - 17907) **Fee:** $167.55 **Benefit:** 75% = $125.70 85% = $142.45
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300, 52303, 52306 or 52324 applies (AU 14 - 17914) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
52333	CLEFT PALATE, primary repair (AU 14 - 17914) **Fee:** $557.00 **Benefit:** 75% = $417.75 85% = $529.30
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (AU 13 - 17913) **Fee:** $348.15 **Benefit:** 75% = $261.15 85% = $320.45
52339	CLEFT PALATE, secondary repair, lengthening procedure (AU 12 - 17912) **Fee:** $396.35 **Benefit:** 75% = $297.30 85% = $368.65
52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (AU 14 - 17914) *(See para OC. of explanatory notes to this Category)* **Fee:** $687.80 **Benefit:** 75% = $515.85 85% = $660.10
52345	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 19 - 17919) *(See para OC. of explanatory notes to this Category)* **Fee:** $775.70 **Benefit:** 75% = $581.80 85% = $748.00

52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (AU 25 - 17925) *(See para OC. of explanatory notes to this Category)* **Fee:** $878.35 **Benefit:** 75% = $658.80 85% = $850.65
52351	MANDIBLE or MAXILLA, bilateral osteotomy of 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 29 - 17929) *(See para OC. of explanatory notes to this Category)* **Fee:** $987.70 **Benefit:** 75% = $740.80 85% = $960.00
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (AU 29 - 17929) *(See para OC. of explanatory notes to this Category)* **Fee:** $998.05 **Benefit:** 75% = $748.55 85% = $970.35
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 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 32 - 17932) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,122.15 **Benefit:** 75% = $841.65 85% =$1,094.45
52360	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (AU 26 - 17926) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,146.15 **Benefit:** 75% = $859.65 85% =$1,118.45
52363	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 2 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 32 - 17932) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,292.80 **Benefit:** 75% = $969.60 85% =$1,265.10
52366	MANDIBLE or MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 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 47 - 17947) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,264.00 **Benefit:** 75% = $948.00 85% =$1,236.30
52369	MANDIBLE or MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 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 50 - 17950) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,416.90 **Benefit:** 75% =$1,062.70 85% =$1,389.20
52372	MANDIBLE or MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 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 50 - 17950) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,376.45 **Benefit:** 75% =$1,032.35 85% =$1,348.75
52375	MANDIBLE or MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 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 59 - 17959) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,541.05 **Benefit:** 75% =$1,155.80 85% =$1,513.35
52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (AU 16 - 17916) *(See para OC. of explanatory notes to this Category)* **Fee:** $532.65 **Benefit:** 75% = $399.50 85% = $504.95
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (AU 18 - 17918) **Fee:** $910.15 **Benefit:** 75% = $682.65 85% = $882.45

52380	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:** $1,551.40 **Benefit:** 75% =$1,163.55 85% =$1,523.70
52382	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:** $1,861.65 **Benefit:** 75% =$1,396.25 85% =$1,833.95
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity **Fee:** $171.70 **Benefit:** 75% = $128.80 85% = $145.95

GROUP O5 - PREPROSTHETIC

52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (AU 10 - 17910) **Fee:** $241.00 **Benefit:** 75% = $180.75 85% = $213.30
52603	MYLOHYLOID RIDGE, reduction of (AU 10 - 17910) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
52606	MAXILLARY TUBEROSITY, reduction of (AU 12 - 17912) **Fee:** $175.65 **Benefit:** 75% = $131.75 85% = $149.35
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (AU 10 - 17910) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (AU 12 - 17912) **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (AU 13 - 17913) **Fee:** $358.85 **Benefit:** 75% = $269.15 85% = $331.15
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (AU 19 - 17919) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (AU 19 - 17919) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (AU 13 - 17913) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (AU 13 - 17913) **Fee:** $206.85 **Benefit:** 75% = $155.15 85% = $179.15
52627	OSSEO-INTEGRATION PROCEDURE - extra oral implantation of titanium fixture (AU 11 - 17911) **Fee:** $358.85 **Benefit:** 75% = $269.15 85% = $331.15
52630	OSSEO-INTEGRATION PROCEDURE - fixation of transcutaneous abutment (AU 6 - 17906) **Fee:** $132.85 **Benefit:** 75% = $99.65 85% = $112.95

GROUP O6 - NEUROSURGICAL

52800	NEUROLYSIS BY OPEN OPERATION, without transposition, not being a service associated with a service to which item 52803 applies (AU 7 - 17907) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
52803	NERVE TRUNK, internal (interfasicular), NEUROLYSIS of, using microsurgical techniques (AU 11 - 17911) **Fee:** $283.85 **Benefit:** 75% = $212.90 85% = $256.15
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve (AU 8 - 17908) **Fee:** $197.10 **Benefit:** 75% = $147.85 85% = $169.40
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve (AU 10 - 17910) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
52812	NERVE TRUNK, PRIMARY repair of, using microsurgical techniques (AU 8 - 17908) **Fee:** $482.05 **Benefit:** 75% = $361.55 85% = $454.35
52815	NERVE TRUNK, SECONDARY repair of, using microsurgical techniques (AU 9 - 17909) **Fee:** $508.80 **Benefit:** 75% = $381.60 85% = $481.10
52818	NERVE, TRANSPOSITION OF (AU 8 - 17908) **Fee:** $337.40 **Benefit:** 75% = $253.05 85% = $309.70
52821	NERVE GRAFT TO NERVE TRUNK (cable graft) including harvesting of nerve graft using microsurgical techniques (AU 16 - 17916) **Fee:** $733.75 **Benefit:** 75% = $550.35 85% = $706.05
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (AU 8 - 17908) **Fee:** $316.00 **Benefit:** 75% = $237.00 85% = $288.30

GROUP O7 - EAR, NOSE & THROAT

53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (AU 6 - 17906) **Fee:** $23.05 **Benefit:** 75% = $17.30 85% = $19.60
53003	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF, where undertaken in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which another item in Groups O3 to O9 applies (AU 6 - 17906) **Fee:** $65.35 **Benefit:** 75% = $49.05 85% = $55.55
53006	ANTROSTOMY (RADICAL) (AU 9 - 17909) **Fee:** $372.35 **Benefit:** 75% = $279.30 85% = $344.65
53009	ANTRUM, intranasal operation on or removal of foreign body from (AU 8 - 17908) **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $182.30
53012	ANTRUM, drainage of, through tooth socket (AU 7 - 17907) **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
53015	ORO-ANTRAL FISTULA, plastic closure of (AU 11 - 17911) **Fee:** $417.75 **Benefit:** 75% = $313.35 85% = $390.05
53018	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (AU 6 - 17906) **Fee:** $97.50 **Benefit:** 75% = $73.15 85% = $82.90
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (AU 20 - 17920) **Fee:** $413.70 **Benefit:** 75% = $310.30 85% = $386.00

GROUP O8 - TEMPOROMANDIBULAR JOINT

53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (AU 4 - 17904) **Fee:** $33.75 **Benefit:** 75% = $25.35 85% = $28.70
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (AU 4 - 17904) **Fee:** $84.60 **Benefit:** 75% = $63.45 85% = $71.95
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in Groups O3 to O9 applies (AU 4 - 17904) **Fee:** $101.75 **Benefit:** 75% = $76.35 85% = $86.50
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (AU 19 - 17919) **Fee:** $1,172.95 **Benefit:** 75% = $879.75 85% =$1,145.25
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (AU 15 - 17915) **Fee:** $636.05 **Benefit:** 75% = $477.05 85% = $608.35
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (AU 9 - 17909) **Fee:** $230.30 **Benefit:** 75% = $172.75 85% = $202.60
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (AU 12 - 17912) **Fee:** $471.30 **Benefit:** 75% = $353.50 85% = $443.60
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (AU 18 - 17918) **Fee:** $621.30 **Benefit:** 75% = $466.00 85% = $593.60
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (AU 20 - 17920) **Fee:** $690.90 **Benefit:** 75% = $518.20 85% = $663.20
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (AU 13 - 17913) **Fee:** $206.85 **Benefit:** 75% = $155.15 85% = $179.15
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including menisectomy when performed, with or without microsurgical techniques (AU 24 - 17924) **Fee:** $846.25 **Benefit:** 75% = $634.70 85% = $818.55
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (AU 24 - 17924) **Fee:** $953.35 **Benefit:** 75% = $715.05 85% = $925.65
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224, 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (AU 28 - 17928) **Fee:** $1,071.15 **Benefit:** 75% = $803.40 85% =$1,043.45

GROUP O9 - TREATMENT OF FRACTURES

53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting *(See para OC. of explanatory notes to this Category)* **Fee:** $92.05 **Benefit:** 75% = $69.05 85% = $78.25
53403	MANDIBLE, treatment of fracture of, not requiring splinting *(See para OC. of explanatory notes to this Category)* **Fee:** $112.45 **Benefit:** 75% = $84.35 85% = $95.60
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (AU 14 - 17914) *(See para OC. of explanatory notes to this Category)* **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (AU 14 - 17914) *(See para OC. of explanatory notes to this Category)* **Fee:** $289.20 **Benefit:** 75% = $216.90 85% = $261.50
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction *(See para OC. of explanatory notes to this Category)* **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (AU 7 - 17907) *(See para OC. of explanatory notes to this Category)* **Fee:** $169.25 **Benefit:** 75% = $126.95 85% = $143.90
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (AU 9 - 17909) *(See para OC. of explanatory notes to this Category)* **Fee:** $278.50 **Benefit:** 75% = $208.90 85% = $250.80
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal and/or external fixation at 2 sites (AU 10 - 17910) *(See para OC. of explanatory notes to this Category)* **Fee:** $342.80 **Benefit:** 75% = $257.10 85% = $315.10
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal and/or external fixation at 3 sites (AU 11 - 17911) *(See para OC. of explanatory notes to this Category)* **Fee:** $391.00 **Benefit:** 75% = $293.25 85% = $363.30
53415	MAXILLA, treatment of fracture of, requiring open reduction (AU 7 - 17907) *(See para OC. of explanatory notes to this Category)* **Fee:** $310.65 **Benefit:** 75% = $233.00 85% = $282.95
53416	MANDIBLE, treatment of fracture of, requiring open reduction (AU 7 - 17907) *(See para OC. of explanatory notes to this Category)* **Fee:** $310.65 **Benefit:** 75% = $233.00 85% = $282.95
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (AU 9 - 17909) *(See para OC. of explanatory notes to this Category)* **Fee:** $401.70 **Benefit:** 75% = $301.30 85% = $374.00
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (AU 9 - 17909) *(See para OC. of explanatory notes to this Category)* **Fee:** $401.70 **Benefit:** 75% = $301.30 85% = $374.00
53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (AU 11 - 17911) *(See para OC. of explanatory notes to this Category)* **Fee:** $514.15 **Benefit:** 75% = $385.65 85% = $486.45

53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (AU 11 - 17911) *(See para OC. of explanatory notes to this Category)* **Fee:** $514.15 **Benefit:** 75% = $385.65 85% = $486.45
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (AU 10 - 17910) *(See para OC. of explanatory notes to this Category)* **Fee:** $439.20 **Benefit:** 75% = $329.40 85% = $411.50
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (AU 10 - 17910) *(See para OC. of explanatory notes to this Category)* **Fee:** $439.20 **Benefit:** 75% = $329.40 85% = $411.50
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (AU 12 - 17912) *(See para OC. of explanatory notes to this Category)* **Fee:** $599.85 **Benefit:** 75% = $449.90 85% = $572.15
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (AU 12 - 17912) *(See para OC. of explanatory notes to this Category)* **Fee:** $599.85 **Benefit:** 75% = $449.90 85% = $572.15
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (AU 6 - 17906) *(See para OC. of explanatory notes to this Category)* **Fee:** $169.25 **Benefit:** 75% = $126.95 85% = $143.90
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (AU 12 - 17912) **Fee:** $346.45 **Benefit:** 75% = $259.85 85% = $318.75
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (AU 14 - 17914) **Fee:** $403.35 **Benefit:** 75% = $302.55 85% = $375.65

INDEX TO
ORAL AND MAXILLOFACIAL SERVICES

* Payable on attendance basis

Service	Item
L	
Lacerations, repair and suturing of	52000-52009
Lavage and proof puncture of maxillary antrum	53000,53003
Le Fort osteotomies	52380,52382
Lingual artery or vein, ligation of	52141
Lip, full thickness wedge excision of	52108
Lipoma, removal of	52036-52045
Local flap repair, single stage	52300,52303,52306
Lymph gland or node, biopsy of	52027
Lymphoid patches, removal of	52036-52045
M	
Mandible, dislocation, treatment of	53200,53203
fixation by intermaxillary wiring	52420
hemi-mandiblectomy of	52120
hemi-mandibular reconstruction with bone graft	52122
operation on, for osteomyelitis	52090
or maxilla, fractures, treatment of	53400-53439
osteectomy or osteotomy of	52342-52375
removal of one or more plates	52105
removal of buried wire, pin or screw	52099,52102
segmental resection of, for tumours or cysts	52114
sub-total resection of	52117
total resection of	52123
Mandibular artery or vein, ligation of	52141
exostosis, excision of	52600
frenulum, repair of	52084
Maxilla, operation on, for osteomyelitis	52090
or mandible, fractures, treatment of	53400-53439
osteectomy or osteotomy of	52342-52375
removal of buried wire, pin or screw	52099,52102
removal of one or more plates	52105
sub-total resection of	52117
total resection of	52126,52129
Maxillary antrum, proof puncture and lavage of	53000,53003
artery, ligation of	52138
frenulum, repair of	52084
sinus, drainage of, through tooth socket	53012
sinus, operations on	53006,53009
sinus, sinus lift procedure	53019
tuberosity, reduction of	52606
Melanoma, excision of	52036-52045
Microsomia, hemifacial, construction condyle and ramus	53212
Mouth, lowering of floor of (Obwegeser or similar)	52621
Mucous membrane, biopsy of	52024
membrane, repair of recent wound of	52000-52009
Muscle, biopsy of	52027
excision of	52060
or other deep tissue, removal of foreign body	52018
Mylohyloid ridge, reduction of	52603
N	
Naevus, excision of	52036-52045
Nerve, peripheral, neurectomy/neurotomy/tumour	52806,52809
transposition of	52818
trigeminal, cryosurgery of	52824
trunk, graft to	52821
trunk, neurolysis of	52803
trunk, repair of	52812,52815
Neurectomy, peripheral nerve	52806,52809
Neurolysis by open operation	52800
of nerve trunk	52803
Neurotomy, peripheral nerve	52806,52809
Node, lymph, biopsy of	52027
O	
Operative procedure not otherwise covered	52001
Orbital cavity, bone or cartilage graft to wall or floor	53455
cavity, reconstruction of wall or floor	53453
Oro-antral fistula, plastic closure of	53015
Orthopaedic pin or wire, insertion of	52096
pin or wire, removal of	52099,52102
plates, removal of	52105
Osseointegration procedure	52627,52630
Osteectomy of mandible or maxilla	52342-52375
Osteomyelitis, operation on mandible or maxilla	52090
operation on skull	52092
Osteotomies, mid-facial	52380,52382
Osteotomy of mandible or maxilla	52342-52375
P	
Palatal exostosis, excision of	52600
Palate, cleft, repair of	52333,52336,52339
papillary hyperplasia, removal of	52609,52612,52615
plastic closure of defect of	52330
Papillary hyperplasia of the palate, removal of	52609,52612,52615
Papilloma, removal of	52036-52045
Parotid duct, repair of	52148
Pin, orthopaedic, insertion of	52096
orthopaedic, removal of	52099,52102
Plastic repair, free grafts	52309,52312,52315
repair, single stage, local flap	52300,52303,52306
Plates, orthopaedic, removal of	52015,52018
Preauricular sinus operations	52030
Proof puncture of maxillary antrum	53000,53003
R	
Radical antrostomy	53006
Ranula, removal of	52087
Reduction of dislocation of mandible	53200,53203
Rodent ulcer, operation for	52036-52045
S	
Salivary gland duct, diathermy or dilatation of	52072
gland duct, removal of calculus from	52075
gland duct, transposition of	52147
gland, incision of	52057
Scar, removal of, not otherwise covered	52036-52045
Sebaceous cyst, removal of	52036-52045
Segmental resection of mandible of maxilla for tumours	52114
Single stage local flap repair	52300,52303,52306
Sinus, excision of	52030,52033
maxillary, drainage of, through tooth socket	53012
Skin, biopsy of	52024
repair of recent wound of	52000-52009
Skull, operation on, for osteomyelitis	52092
Subcutaneous foreign body, removal, other	52015
tissue, repair of recent wound of	52000-52009
Sublingual gland duct, removal of calculus from	52075
gland, extirpation of	52069
Submandibular abscess, incision of	52057
gland, extirpation of	52066
gland, incision of	52057
Submaxillary gland, extirpation of	52066

* Payable on attendance basis

* Payable on attendance basis

DIAGNOSTIC IMAGING SERVICES

CATEGORY 5

PLEASE NOTE:

The information contained in this Category relates specifically to the Diagnostic Imaging Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the FOREWORD and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.

CATEGORY 5 - DIAGNOSTIC IMAGING SERVICES

OUTLINE OF ARRANGEMENTS

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 5 - DIAGNOSTIC IMAGING SERVICES

OUTLINE OF ARRANGEMENTS

DIA. DIAGNOSTIC IMAGING SERVICES IN RELATION TO MEDICARE BENEFITS

DIA.1 Introduction

Changes to the Health Insurance Act from 1 May 1991 imposed certain conditions on the payment of Medicare benefits for diagnostic imaging services and prohibiting certain practices in the provision of those services. The services currently covered by this legislation are diagnostic radiology, CT scanning, ultrasound and nuclear scanning.

Under this legislation, 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 and certain other services, the requesting practitioner may also be a dental practitioner, a prosthodontist or oral and maxillofacial surgeon. For X-rays of the spine and pelvic region the requesting practitioner may also be a chiropractor or a physiotherapist and for specified X-rays of the foot the requesting practitioner may also be a podiatrist. (see DIA.4.8)

To help in defining a diagnostic imaging service, a separate Diagnostic Imaging Services Table was established.

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 55029, 55031, 55033, 55035, 55037, 55039, 55041, 55043, 55045, 55049, 55051, 55053, 55055 and 55057, the following items in Group I3, diagnostic radiology - Items 57500, 57506, 57512, 57518, 57524, 57700, 57706, 58500, 58515, 58900, 60072, 60075, 60078 - and all items in Subgroup I3.18 (Preparation). All other diagnostic imaging services are classified "R-type" services. The items in Subgroup I3.18 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 (the treating practitioner). A valid request can be made by a medical practitioner on behalf of the treating practitioner, for example by a resident medical officer at a hospital on behalf of the patient's practitioner.

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

DIA.4.2 *Specialist*
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, chiropractor, physiotherapist or podiatrist 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, chiropractors, physiotherapists or podiatrists, the lost request exemption is applicable only to radiographic examinations of the specific areas they can request. 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 1995 as the legislation provides that, from that date, the exemption provision is automatically repealed.

The above exemption applies to the services covered by the following items: 57712, 57715, 57718, 57900, 57903, 57912, 57915, 57921, 58100, 58103, 58106, 58109, 58112, 58115, 58118, 58521, 58524, 58527, 58700, 58924 and 59103.

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

DIA.4.8 Diagnostic Imaging Services Requested by Dental Practitioners, Chiropractors, Physiotherapists and Podiatrists

The legislation specifies (R) type diagnostic imaging services which may be requested by dental practitioners, chiropractors, physiotherapists and podiatrists, subject to the requirements of State and Territory laws.

Dental practitioners (including oral and maxillofacial surgeons and prosthodontists) may request the following items:

57503	57509	57515	57521	57527	57900	57903	57906	57909	57912	57915	57918	57921	57924
57927	57930	57933	57936	57939	57942	57945	58100	58300	58303	58503	58903	59733	59739
59748	59751	60100	60500	60503	60700								

Oral and maxillofacial surgeons may also request the following items:

55028	55030	55032	55050	55052	56000	56003	56006	56009	56012	56015	56018	56021	56024
56027	56100	56103	56106	56200	56203	56206	56209	56212	56215	56218	56300	56303	56306
56400	56403	56406	56500	56503	56506	56700	56703	56706	56800	56803	56806	56900	56903
56906	57000	57003	57006	57100	57103	57106	57340	57400	57403	57406	57703	57709	57712
57715	57718	58103	58106	58109	58112	58115	58118	58306	58506	58509	58521	58524	58527
58906	59100	59103	59703	59742	59745	59924	60000	60003	60006	60009	60506	60509	61109
61370	61371	61419	61420	61435	61436	61451	61452	61455	61456	61459	61460	61501	61502

Prosthodontists may also request the following items:

55050	55052	56012	56015	56018	56021	56024	56027	61435	61436	61447	61448	61451	61452
61455	61456	61459	61460	61501	61502								

Chiropractors and physiotherapists may request the following items:

57712	57715	57718	58100	58103	58106	58109	58112	58115	58118

Podiatrists may request the following items:

57503	57521	57525

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 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 Managing Director 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. A written request must also contain the name and address or name and provider number of the requesting practitioner and be signed and dated by 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 offence 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, 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 follow:

- 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".

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 Managing Director 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 Managing Director'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 Managing Director 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 Managing Director 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:

(a) that is 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;
(b) that is more than 30 kilometres by road from a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology; and
(c) where the facilities for rendering R-type diagnostic imaging services in the area in which the practice is situated (including facilities provided by practitioners visiting the area regularly) are such that patients in the area would suffer physical or financial hardship.

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 Managing Director, Health Insurance Commission, c/o General Manager, Medicare 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 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 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 benefit 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 of 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 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 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 the ultrasound scanning.

As a rule, benefit is payable once only for ultrasonic examination at the one attendance, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, "attendance" means that there is a clear separation between one service and the next. For example, from 1 November 1993, where there is a short time between one ultrasound and the next, benefits will be payable for one service only - as a guide, the Health Insurance Commission will look to a separation of 3 hours between services and this must be stated on accounts issued for more than 1 service on the one day.

However, where more than one ultrasound service is rendered on the one occasion and the additional service relates to a non-contiguous body area (and the services provided are "clinically relevant", that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered), additional benefits may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning, such as between abdomen and pelvis. Accounts should be endorsed "contiguous body area with different setup requirements".

Note that ultrasound of one or more musculo-skeletal areas is a single item payable only once irrespective of the number of regions scanned.

DIH.2 Routine Ultrasonic Scanning
Medicare benefits are not attracted for routine ultrasonic screening associated with the termination of pregnancy.

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

DIH.3 Investigations of Vascular Disease (Items 55201-55237)
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.

DIH.4 Urological - Transrectal Ultrasound (Items 55300 and 55303)

Benefits for these items are attracted only where the service is rendered in the circumstances specified in both items. These provide that -

- a digital rectal examination was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the equipment used meets specifications; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Item 55300 provides for the service where rendered by a medical practitioner who **did not** assess the patient, whereas item 55303 provides for the service where rendered by a medical practitioner who **did** assess the patient.

DII. COMPUTERISED TOMOGRAPHY (excluding Magnetic Resonance Imaging - see Note DIL.)

DII.1 General
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
Items have been provided to cover the common combinations of regions - see DII.6. However, where regions are scanned on the one occasion which are not covered by a combination item, for example, Item 56000 (scan of brain) and Item 56603 (scan of extremities), both examinations would attract separate benefit.

DII.3 CT Scan of Temporal Bones with Air Study - (Item 56018)
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 56218)
The intrathecal injection of contrast medium attracts benefit under Item 60957.

DII.5 CT Scan of Extremities - (Items 56600-56624)
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 56700-57106)
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
The benefits allocated to each item from 57500 to 60981 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
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
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 (Item 58900/58903)
Benefits are not attracted for Items 58900/58903 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 59300 and 59303)
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 referral letter or note (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.

DIJ.6 Digital Subtraction Angiography (Items 60000-60078)
Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items 60000 to 60069). For selective DSA - 1 DSA item (from Items 60000 to 60069) and 1 item covering selective catheterisation (from 60072, 60075 or 60078). If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

DIJ.7 Study of region or organ not covered by any other item in this Group (Item 60700)
A nominal fee only has been allocated to this item. The procedure to be adopted for the purpose of facilitating payment of Medicare benefits is outlined at paragraph 10.1 et seq. of the General Explanatory Notes to this book.

DIK. NUCLEAR MEDICINE IMAGING

DIK.1 General
There is a differential fee structure for items covering nuclear medicine depending on whether or not the service is performed at a computerised installation.

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

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

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.

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.

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 Category 1 of the Schedule where there is a request for a full medical examination accompanied by a referral letter or note.

DIK.2 Radiopharmaceuticals
The Schedule fees for nuclear medicine investigations incorporate the costs of radiopharmaceuticals.

DIK.3 Study of region or organ not covered by any other item in this Group (Items 61501/61502)
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 10.1 et seq. of the General Explanatory Notes to this book.

DIL. MAGNETIC RESONANCE IMAGING

DIL.1 Non payment of Medicare Benefits for Magnetic Resonance Imaging (MRI)
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-compensible) patients. The grants were effective from 1 February 1992, rendering the Medicare benefit item superfluous.

Patients eligible for Medicare and private (non-compensible) 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 access to publicly funded MRI is based on demonstrated needs and health outcomes, and that inappropriate diffusion of this expensive health technology does not occur.

DIL.2 Anaesthetic Services Associated with MRI
Medicare benefits are payable under Item 18013 for anaesthetic services associated with MRI. Benefits are restricted to anaesthetic services administered in association with MRI services carried out using MRI equipment located at the hospitals listed above.

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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45

‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $96.20 **Benefit:** 75% = $72.15 85% = $81.80

‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $96.20 **Benefit:** 75% = $72.15 85% = $81.80
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 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 item 55055 or an item in Subgroups 2 or 3 of 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) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
‡ 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 item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $33.25 **Benefit:** 75% = $24.95 85% = $28.30
‡ 55054	ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45
55055	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, not being a service associated with a service to which another item in this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $58.00 **Benefit:** 75% = $43.50 85% = $49.30
‡ 55056	ULTRASOUND SCAN not otherwise specified, not being a service associated with a service to which item 55055 or an item in Subgroups 2 or 3 of this Group applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $20.70 **Benefit:** 75% = $15.55 85% = $17.60
‡ 55057	ULTRASOUND SCAN not otherwise specified, not being a service associated with a service to which item 55055 or an item in Subgroups 2 or 3 of this Group applies (NR) *(See para DIH. of explanatory notes to this Category)* **Fee:** $5.05 **Benefit:** 75% = $3.80 85% = $4.30
	SUBGROUP 2 - CARDIAC
55102	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION OF THE HEART FROM AT LEAST 2 THORACIC WINDOWS, performed using a mechanical sector scanner or phased array transducer, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, with recordings on video tape, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) **Fee:** $157.20 **Benefit:** 75% = $117.90 85% = $133.65
55105	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 thoracic windows, performed using a mechanical sector scanner or phased array transducer, with measurement of cardiac dimensions, with recordings on video tape, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) **Fee:** $88.95 **Benefit:** 75% = $66.75 85% = $75.65

55112	M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 thoracic windows, performed using a mechanical sector scanner or phased array transducer, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, together with real time colour flow mapping from at least 2 thoracic windows, with recordings on video tape, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) **Fee:** $243.05 **Benefit:** 75% = $182.30 85% = $215.35
55118	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 an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) **Fee:** $242.60 **Benefit:** 75% = $181.95 85% = $214.90
55130	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure (R) **Fee:** $346.45 **Benefit:** 75% = $259.85 85% = $318.75
	SUBGROUP 3 - VASCULAR
55201	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 an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - 1 examination and report (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $165.50 **Benefit:** 75% = $124.15 85% = $140.70
55204	- 2 or more examinations of the kind referred to in item 55201 and report, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $284.40 **Benefit:** 75% = $213.30 85% = $256.70
55225	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis of carotid vessels, with oculoplethysmography, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - examination and report (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $198.60 **Benefit:** 75% = $148.95 85% = $170.90
55231	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 being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - examination and report (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $320.60 **Benefit:** 75% = $240.45 85% = $292.90
55234	DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis, of peripheral vessels, including a service referred to in item 11603, 11606 or 11609, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - examination and report (R) *(See para DIH. of explanatory notes to this Category)* **Fee:** $192.35 **Benefit:** 75% = $144.30 85% = $164.65

DUPLEX SCANNING (unilateral or bilateral) involving B mode ultrasound imaging and integrated Doppler flow measurement by spectral analysis of peripheral vessels before measured exercise using treadmill or bicycle ergometer, and measurement of pressure after exercise for 10 minutes or until pressure is normal (unilateral or bilateral), not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - examination and report (R)
(See para DIH. of explanatory notes to this Category)

55237 **Fee:** $212.00 **Benefit:** 75% = $159.00 85% = $184.30

SUBGROUP 4 - UROLOGICAL

‡ PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed:
(a) personally by a medical practitioner, not being the medical practitioner who assessed the patient as specified in (c) using a transducer probe or probes which have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz and able to obtain both axial and sagittal scans in 2 planes at right angles; and
(b) following a digital rectal examination of the prostate by that medical practitioner; and
(c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has:
(i) examined the patient in the 60 days prior to the scan; and
(ii) recommended the scan for the management of the patient's current prostatic disease (R)
(See para DIH. of explanatory notes to this Category)

55300 **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45

† PROSTATE, bladder base and urethra, transrectal ultrasound scan of, where performed:
(a) personally by a medical practitioner who undertook the assessment referred to in (c) using a transducer probe or probes which have a nominal frequency of 7 to 7.5 megahertz or a nominal frequency range which includes frequencies of 7 to 7.5 megahertz and able to obtain both axial and sagittal scans in 2 planes at right angles; and
(b) following a digital rectal examination of the prostate by that medical practitioner; and
(c) on a patient who has been assessed by a specialist in urology, radiation oncology or medical oncology or a consultant physician in medical oncology who has:
(i) examined the patient in the 60 days prior to the scan; and
(ii) recommended the scan for the management of the patient's current prostatic disease (R)
(See para DIH. of explanatory notes to this Category)

55303 **Fee:** $95.80 **Benefit:** 75% = $71.85 85% = $81.45

GROUP I2 - COMPUTERISED TOMOGRAPHY (EXCLUDING MAGNETIC RESONANCE IMAGING)

SUBGROUP 1 - COMPUTERISED TOMOGRAPHY ON A BODY SCANNER AND REPORT

HEAD

56000	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with or without scan of internal auditory meatus without intravenous contrast medium (not being a service to which item 57000 or 57100 applies) (R) **Fee:** $143.00 **Benefit:** 75% = $107.25 85% = $121.55
56003	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with or without scan of internal auditory meatus with intravenous contrast medium (not being a service to which item 57003 or 57103 applies) (R) **Fee:** $198.60 **Benefit:** 75% = $148.95 85% = $170.90
56006	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with or without scan of internal auditory meatus without intravenous contrast medium (minimum of 8 slices) with intravenous contrast medium (not being a service to which item 57006 or 57106 applies) (R) **Fee:** $234.60 **Benefit:** 75% = $175.95 85% = $206.90
56009	COMPUTERISED TOMOGRAPHY - SCAN OF PITUITARY FOSSA by multiple thin slices (including reconstructions) with or without intravenous contrast medium or brain scan (R) **Fee:** $474.65 **Benefit:** 75% = $356.00 85% = $446.95
56012	COMPUTERISED TOMOGRAPHY - SCAN OF ORBITS by multiple thin slices (including reconstructions) with or without intravenous contrast medium or brain scan (R) **Fee:** $469.20 **Benefit:** 75% = $351.90 85% = $441.50
56015	COMPUTERISED TOMOGRAPHY - SCAN OF MIDDLE EAR AND TEMPORAL BONE, unilateral or bilateral, detailed study by multiple thin slices (including reconstructions) with or without intravenous contrast medium or brain scan (R) **Fee:** $458.30 **Benefit:** 75% = $343.75 85% = $430.60
56018	COMPUTERISED TOMOGRAPHY - SCAN OF TEMPORAL BONES WITH AIR STUDY (including reconstructions), including intrathecal injection, but not including an associated brain scan (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $369.35 **Benefit:** 75% = $277.05 85% = $341.65
56021	COMPUTERISED TOMOGRAPHY - SCAN OF FACIAL BONES, sinuses and salivary glands - scan of 1 or more regions without intravenous contrast medium (R) **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
56024	COMPUTERISED TOMOGRAPHY - SCAN OF FACIAL BONES, sinuses and salivary glands - scan of 1 or more regions with intravenous contrast medium (R) **Fee:** $272.80 **Benefit:** 75% = $204.60 85% = $245.10
56027	COMPUTERISED TOMOGRAPHY - SCAN OF FACIAL BONES, sinuses and salivary glands - scan of 1 or more regions without and with intravenous contrast medium (R) **Fee:** $387.35 **Benefit:** 75% = $290.55 85% = $359.65

NECK

56100	COMPUTERISED TOMOGRAPHY - SCAN OF SOFT TISSUES OF NECK, including larynx, pharynx and upper oesophagus (not associated with cervical spine) - scan of 1 or more regions without intravenous contrast medium (not being a service to which item 56900 applies) (R) **Fee:** $369.35 **Benefit:** 75% = $277.05 85% = $341.65
56103	COMPUTERISED TOMOGRAPHY - SCAN OF SOFT TISSUES OF NECK, including larynx, pharynx and upper oesophagus (not associated with cervical spine) - scan of 1 or more regions with intravenous contrast medium (not being a service to which item 56903 applies) (R) **Fee:** $398.25 **Benefit:** 75% = $298.70 85% = $370.55

56106	COMPUTERISED TOMOGRAPHY - SCAN OF SOFT TISSUES OF NECK, including larynx, pharynx and upper oesophagus (not associated with cervical spine) - scan of 1 or more regions without and with intravenous contrast medium (not being a service to which item 56906 applies) (R) **Fee:** $436.45 **Benefit:** 75% = $327.35 85% = $408.75
	SPINE
56200	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions, 25 slices or less without intravenous contrast medium (R) **Fee:** $181.10 **Benefit:** 75% = $135.85 85% = $153.95
56203	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions, 25 slices or less with intravenous contrast medium (R) **Fee:** $211.70 **Benefit:** 75% = $158.80 85% = $184.00
56206	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions, 25 slices or less without and with intravenous contrast medium (R) **Fee:** $283.70 **Benefit:** 75% = $212.80 85% = $256.00
56209	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions, 26 or more slices without intravenous contrast medium (R) **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
56212	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions, 26 or more slices with intravenous contrast medium (R) **Fee:** $283.70 **Benefit:** 75% = $212.80 85% = $256.00
56215	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions, 26 or more slices without and with intravenous contrast medium (R) **Fee:** $398.25 **Benefit:** 75% = $298.70 85% = $370.55
56218	COMPUTERISED TOMOGRAPHY - SCAN OF SPINE, 1 or more regions with intrathecal contrast medium, not including the preparation by intrathecal injection of contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
	CHEST
56300	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, including lungs, mediastinum and pleura, without intravenous contrast medium (not being a service to which item 56700, 56800, 56900, 57000 or 57100 applies) (R) **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
56303	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, including lungs, mediastinum and pleura, with intravenous contrast medium (not being a service to which item 56703, 56803, 56903, 57003 or 57103 applies) (R) **Fee:** $294.60 **Benefit:** 75% = $220.95 85% = $266.90
56306	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, including lungs, mediastinum and pleura, without intravenous contrast medium (minimum of 8 slices) and with intravenous contrast medium (not being a service to which item 56706, 56806, 56906, 57006 or 57106 applies) (R) **Fee:** $371.00 **Benefit:** 75% = $278.25 85% = $343.30
	UPPER ABDOMEN
56400	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN (diaphragm to iliac crest) or PELVIS without intravenous contrast medium (not being a service to which item 56700, 56800, 56900 or 57100 applies) (R) **Fee:** $143.00 **Benefit:** 75% = $107.25 85% = $121.55
56403	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN (diaphragm to iliac crest) or PELVIS with intravenous contrast medium (not being a service to which item 56703, 56803, 56903 or 57103 applies) (R) **Fee:** $174.60 **Benefit:** 75% = $130.95 85% = $148.45
56406	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 being a service to which item 56706, 56806, 56906 or 57106 applies) (R) **Fee:** $283.70 **Benefit:** 75% = $212.80 85% = $256.00

	UPPER ABDOMEN AND PELVIS
56500	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN AND PELVIS without intravenous contrast medium (not being a service to which item 56700, 56800, 56900 or 57100 applies) (R) **Fee:** $219.25 **Benefit:** 75% = $164.45 85% = $191.55
56503	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN AND PELVIS with intravenous contrast medium (not being a service to which item 56703, 56803, 56903 or 57103 applies) (R) **Fee:** $261.85 **Benefit:** 75% = $196.40 85% = $234.15
56506	COMPUTERISED TOMOGRAPHY - SCAN OF UPPER ABDOMEN AND PELVIS without intravenous contrast medium (minimum of 8 slices) and with intravenous contrast medium (not being a service to which item 56706, 56806, 56906 or 57106 applies) (R) **Fee:** $371.00 **Benefit:** 75% = $278.25 85% = $343.30
	EXTREMITIES
56600	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving up to 20 slices without intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $143.00 **Benefit:** 75% = $107.25 85% = $121.55
56603	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving up to 20 slices with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $174.60 **Benefit:** 75% = $130.95 85% = $148.45
56606	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving up to 20 slices without and with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $211.70 **Benefit:** 75% = $158.80 85% = $184.00
56609	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving more than 20 slices but not more than 40 slices without intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $181.10 **Benefit:** 75% = $135.85 85% = $153.95
56612	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving more than 20 slices but not more than 40 slices with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $211.70 **Benefit:** 75% = $158.80 85% = $184.00
56615	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving more than 20 slices but not more than 40 slices without and with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $283.70 **Benefit:** 75% = $212.80 85% = $256.00
56618	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving more than 40 slices without intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
56621	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving more than 40 slices with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $283.70 **Benefit:** 75% = $212.80 85% = $256.00
56624	COMPUTERISED TOMOGRAPHY - SCAN OF EXTREMITIES, 1 OR MORE REGIONS involving more than 40 slices without and with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $360.05 **Benefit:** 75% = $270.05 85% = $332.35

	CHEST AND UPPER ABDOMEN
56700	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) without intravenous contrast medium (not being a service to which item 56800, 56900 or 57100 applies) (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
56703	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) with intravenous contrast medium (not being a service to which item 56803, 56903 or 57103 applies) (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $300.05 **Benefit:** 75% = $225.05 85% = $272.35
56706	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST AND UPPER ABDOMEN (from lung apices to iliac crest) without and with intravenous contrast medium (not being a service to which item 56806, 56906 or 57106 applies) (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $376.45 **Benefit:** 75% = $282.35 85% = $348.75
	CHEST, ABDOMEN AND PELVIS
56800	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, ABDOMEN AND PELVIS without intravenous contrast medium (not being a service to which item 56900 applies) (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $333.65 **Benefit:** 75% = $250.25 85% = $305.95
56803	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, ABDOMEN AND PELVIS with intravenous contrast medium (not being a service to which item 56903 applies) (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $376.45 **Benefit:** 75% = $282.35 85% = $348.75
56806	COMPUTERISED TOMOGRAPHY - SCAN OF CHEST, ABDOMEN AND PELVIS without and with intravenous contrast medium (not being a service to which item 56906 applies) (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $529.20 **Benefit:** 75% = $396.90 85% = $501.50
	NECK, CHEST, ABDOMEN AND PELVIS
56900	COMPUTERISED TOMOGRAPHY - SCAN OF NECK, CHEST, ABDOMEN AND PELVIS without intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $482.55 **Benefit:** 75% = $361.95 85% = $454.85
56903	COMPUTERISED TOMOGRAPHY - SCAN OF NECK, CHEST, ABDOMEN AND PELVIS with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $529.20 **Benefit:** 75% = $396.90 85% = $501.50
56906	COMPUTERISED TOMOGRAPHY - SCAN OF NECK, CHEST, ABDOMEN AND PELVIS without and with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $638.30 **Benefit:** 75% = $478.75 85% = $610.60
	BRAIN AND CHEST
57000	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN AND CHEST without intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $256.20 **Benefit:** 75% = $192.15 85% = $228.50
57003	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN AND CHEST with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $300.05 **Benefit:** 75% = $225.05 85% = $272.35
57006	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN AND CHEST without and with intravenous contrast medium (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $414.65 **Benefit:** 75% = $311.00 85% = $386.95

	CHEST AND UPPER ABDOMEN AND BRAIN
57100	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 DII. of explanatory notes to this Category)* **Fee:** $369.35 **Benefit:** 75% = $277.05 85% = $341.65
57103	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 DII. of explanatory notes to this Category)* **Fee:** $414.65 **Benefit:** 75% = $311.00 85% = $386.95
57106	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 DII. of explanatory notes to this Category)* **Fee:** $529.20 **Benefit:** 75% = $396.90 85% = $501.50
	PELVIMETRY
57200	COMPUTERISED TOMOGRAPHY - PELVIMETRY (R) **Fee:** $143.00 **Benefit:** 75% = $107.25 85% = $121.55
	DYNAMIC SCAN OF REGION
57300	COMPUTERISED TOMOGRAPHY - DYNAMIC SCAN OF REGION not being a service associated with a service to which another item in this Group applies (R) **Fee:** $174.60 **Benefit:** 75% = $130.95 85% = $148.45
57303	COMPUTERISED TOMOGRAPHY - DYNAMIC SCAN OF REGION being a service associated with a service to which another item in this Group applies (R) **Derived Fee:** The fee for computerised tomography of the area and report plus an amount of $111.70
	INTERVENTIONAL TECHNIQUES
57340	COMPUTERISED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this Category applies (R) **Fee:** $258.55 **Benefit:** 75% = $193.95 85% = $230.85
	SUBGROUP 2 - COMPUTERISED TOMOGRAPHY ON A BRAIN SCANNER AND REPORT
57400	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN without intravenous contrast medium (R) **Fee:** $72.70 **Benefit:** 75% = $54.55 85% = $61.80
57403	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN with intravenous contrast medium (R) **Fee:** $88.40 **Benefit:** 75% = $66.30 85% = $75.15
57406	COMPUTERISED TOMOGRAPHY - SCAN OF BRAIN without and with intravenous contrast medium (R) **Fee:** $137.50 **Benefit:** 75% = $103.15 85% = $116.90

GROUP I3 - DIAGNOSTIC RADIOLOGY

SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES AND REPORT

57500	DIGITS OR PHALANGES - all or any of either hand or either foot (NR) **Fee:** $29.90 **Benefit:** 75% = $22.45 85% = $25.45
57503	DIGITS OR PHALANGES - all or any of either hand or either foot (R) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
57506	HAND, WRIST, FOREARM, ELBOW OR ARM (elbow to shoulder) (NR) **Fee:** $29.90 **Benefit:** 75% = $22.45 85% = $25.45
57509	HAND, WRIST, FOREARM, ELBOW OR ARM (elbow to shoulder) (R) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
57512	HAND, WRIST AND LOWER FOREARM OR UPPER FOREARM AND ELBOW OR ELBOW AND ARM (elbow to shoulder) (NR) **Fee:** $40.65 **Benefit:** 75% = $30.50 85% = $34.60
57515	HAND, WRIST AND LOWER FOREARM OR UPPER FOREARM AND ELBOW OR ELBOW AND ARM (elbow to shoulder) (R) **Fee:** $54.20 **Benefit:** 75% = $40.65 85% = $46.10
57518	FOOT, ANKLE, LOWER LEG, UPPER LEG, KNEE OR THIGH (femur) (NR) **Fee:** $32.70 **Benefit:** 75% = $24.55 85% = $27.80
57521	FOOT, ANKLE, LOWER LEG, UPPER LEG, KNEE OR THIGH (femur) (R) **Fee:** $43.60 **Benefit:** 75% = $32.70 85% = $37.10
57524	FOOT, ANKLE AND LOWER LEG OR UPPER LEG AND KNEE (NR) **Fee:** $49.55 **Benefit:** 75% = $37.20 85% = $42.15
57527	FOOT, ANKLE AND LOWER LEG OR UPPER LEG AND KNEE (R) **Fee:** $66.05 **Benefit:** 75% = $49.55 85% = $56.15

SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS AND REPORT

57700	SHOULDER OR SCAPULA (NR) **Fee:** $40.65 **Benefit:** 75% = $30.50 85% = $34.60
57703	SHOULDER OR SCAPULA (R) **Fee:** $54.20 **Benefit:** 75% = $40.65 85% = $46.10
57706	CLAVICLE (NR) **Fee:** $32.70 **Benefit:** 75% = $24.55 85% = $27.80
57709	CLAVICLE (R) **Fee:** $43.60 **Benefit:** 75% = $32.70 85% = $37.10
57712	HIP JOINT (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57715	PELVIC GIRDLE (R) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90

57718	SACRO-ILIAC JOINTS (R) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
	SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD AND REPORT
57900	SKULL (calvarium) (R) **Fee:** $64.80 **Benefit:** 75% = $48.60 85% = $55.10
57903	SINUSES (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57906	MASTOIDS (R) **Fee:** $64.80 **Benefit:** 75% = $48.60 85% = $55.10
57909	PETROUS TEMPORAL BONES (R) **Fee:** $64.80 **Benefit:** 75% = $48.60 85% = $55.10
57912	FACIAL BONES - orbit, maxilla or malar, any or all (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57915	MANDIBLE (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57918	SALIVARY CALCULUS (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57921	NOSE (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57924	EYE (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
57927	TEMPORO-MANDIBULAR JOINTS (R) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40
57930	TEETH - SINGLE AREA (R) **Fee:** $33.05 **Benefit:** 75% = $24.80 85% = $28.10
57933	TEETH - FULL MOUTH (R) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
57936	TEETH, ORTHOPANTOMOGRAPHY (R) **Fee:** $47.55 **Benefit:** 75% = $35.70 85% = $40.45
57939	PALATO-PHARYNGEAL STUDIES with fluoroscopic screening (R) **Fee:** $64.80 **Benefit:** 75% = $48.60 85% = $55.10
57942	PALATO-PHARYNGEAL STUDIES without fluoroscopic screening (R) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40
57945	LARYNX (R) **Fee:** $43.60 **Benefit:** 75% = $32.70 85% = $37.10

	SUBGROUP 4 - RADIOGRAPHIC EXAMINATION OF SPINE AND REPORT
58100	SPINE - CERVICAL (R) **Fee:** $64.80 **Benefit:** 75% = $48.60 85% = $55.10
58103	SPINE - THORACIC (R) **Fee:** $55.45 **Benefit:** 75% = $41.60 85% = $47.15
58106	SPINE - LUMBO-SACRAL (R) **Fee:** $76.05 **Benefit:** 75% = $57.05 85% = $64.65
58109	SPINE - SACRO-COCCYGEAL (R) **Fee:** $46.75 **Benefit:** 75% = $35.10 85% = $39.75
58112	SPINE - 2 REGIONS (R) **Fee:** $95.95 **Benefit:** 75% = $72.00 85% = $81.60
58115	SPINE - 3 OR MORE REGIONS (R) **Fee:** $132.10 **Benefit:** 75% = $99.10 85% = $112.30
58118	SPINE - FUNCTIONAL VIEWS OF 1 AREA (R) **Fee:** $20.70 **Benefit:** 75% = $15.55 85% = $17.60
	SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS AND REPORT
58300	BONE AGE STUDY, WRIST AND KNEE (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
58303	BONE AGE STUDY, WRIST (R) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
58306	SKELETAL SURVEY INVOLVING 4 OR MORE REGIONS (R) **Fee:** $89.75 **Benefit:** 75% = $67.35 85% = $76.30
	SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION AND REPORT
58500	CHEST (lung fields) by direct radiography (NR) **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20
58503	CHEST (lung fields) by direct radiography (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
58506	CHEST (lung fields) by direct radiography WITH FLUOROSCOPIC SCREENING (R) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
58509	THORACIC INLET OR TRACHEA (R) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
58512	CHEST, BY MINIATURE RADIOGRAPHY (R) **Fee:** $21.95 **Benefit:** 75% = $16.50 85% = $18.70
58515	CARDIAC EXAMINATION (including barium swallow) (NR) **Fee:** $45.80 **Benefit:** 75% = $34.35 85% = $38.95

58518	CARDIAC EXAMINATION (including barium swallow) (R) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
58521	STERNUM OR RIBS ON 1 SIDE (R) **Fee:** $43.60 **Benefit:** 75% = $32.70 85% = $37.10
58524	STERNUM AND RIBS ON 1 SIDE OR RIBS ON BOTH SIDES (R) **Fee:** $56.70 **Benefit:** 75% = $42.55 85% = $48.20
58527	STERNUM AND RIBS ON BOTH SIDES (R) **Fee:** $69.80 **Benefit:** 75% = $52.35 85% = $59.35
	SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT AND REPORT
58700	PLAIN RENAL ONLY (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
58703	DRIP-INFUSION PYELOGRAPHY (R) **Fee:** $132.10 **Benefit:** 75% = $99.10 85% = $112.30
58706	INTRAVENOUS PYELOGRAPHY, including preliminary plain film (R) **Fee:** $124.40 **Benefit:** 75% = $93.30 85% = $105.75
58709	INTRAVENOUS PYELOGRAPHY, including preliminary plain film and limited tomography, involving up to 3 tomographic cuts (R) **Fee:** $154.95 **Benefit:** 75% = $116.25 85% = $131.75
58712	INTRAVENOUS PYELOGRAPHY, including preliminary plain film with delayed examination for the CYSTO-URETERIC REFLEX (R) **Fee:** $157.10 **Benefit:** 75% = $117.85 85% = $133.55
58715	ANTEGRADE OR RETROGRADE PYELOGRAPHY - including preliminary plain film (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
58718	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY (R) **Fee:** $66.05 **Benefit:** 75% = $49.55 85% = $56.15
58721	RETROGRADE MICTURATING CYSTO-URETHROGRAPHY (R) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
58724	RETRO-PERITONEAL PNEUMOGRAM (R) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40
	SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM AND REPORT
58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (NR) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $35.50 **Benefit:** 75% = $26.65 85% = $30.20
58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909, 58912, 58915 or 58924 applies (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
58906	OESOPHAGUS, with or without examination for foreign body or barium swallow (R) **Fee:** $67.30 **Benefit:** 75% = $50.50 85% = $57.25

58909	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH AND DUODENUM, with or without screening of chest, with or without preliminary plain film (R) **Fee:** $92.25 **Benefit:** 75% = $69.20 85% = $78.45
58912	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) **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
58918	OPAQUE ENEMA (R) **Fee:** $92.25 **Benefit:** 75% = $69.20 85% = $78.45
58921	OPAQUE ENEMA, including air contrast study (R) **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
58924	GRAHAM'S TEST (cholecystography), including preliminary abdominal radiography (R) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
58927	CHOLEGRAPHY DIRECT - operative or post-operative (R) **Fee:** $76.05 **Benefit:** 75% = $57.05 85% = $64.65
58930	CHOLEGRAPHY - intravenous (R) **Fee:** $109.70 **Benefit:** 75% = $82.30 85% = $93.25
58933	CHOLEGRAPHY - percutaneous transhepatic (R) **Fee:** $89.75 **Benefit:** 75% = $67.35 85% = $76.30
58936	CHOLEGRAPHY - drip infusion (R) **Fee:** $149.55 **Benefit:** 75% = $112.20 85% = $127.15
	SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES AND REPORT
59100	FOREIGN BODY IN EYE (special method, Sweet's or other) (R) **Fee:** $66.05 **Benefit:** 75% = $49.55 85% = $56.15
59103	FOREIGN BODY, LOCALISATION OF AND REPORT, not being a service to which another item in this Group applies (R) **Derived Fee:** The fee for the radiographic examination of the area and report plus an amount of $20.50
	SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS AND REPORT
59300 S	*(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)* RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, (with or without thermography) and report if: (a) the patient is referred with a specific request for this procedure; and (b) there is reason to suspect the presence of malignancy in the breasts because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) (S) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75

59303 S	RADIOGRAPHIC EXAMINATION OF 1 BREAST, (with or without thermography) and report if: (a) the patient is referred with a specific request for this procedure; and (b) there is reason to suspect the presence of malignancy in the breasts because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) (S) *(See para DI]. of explanatory notes to this Category)* **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
59306	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) **Fee:** $90.55 **Benefit:** 75% = $67.95 85% = $77.00
59309	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) **Fee:** $181.15 **Benefit:** 75% = $135.90 85% = $154.00
	SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY AND REPORT
59500	PREGNANT UTERUS (R) **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35
59503	PELVIMETRY OR PLACENTOGRAPHY (R) **Fee:** $89.75 **Benefit:** 75% = $67.35 85% = $76.30
59506	CONTROL X-RAYS IN CONJUNCTION WITH INTRAUTERINE FOETAL BLOOD TRANSFUSION (R) **Fee:** $66.05 **Benefit:** 75% = $49.55 85% = $56.15
	SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA AND REPORT
59700	DISCOGRAPHY - 1 disc (R) **Fee:** $69.80 **Benefit:** 75% = $52.35 85% = $59.35
59703	DACRYOCYSTOGRAPHY - 1 side (R) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25
59706	ENCEPHALOGRAPHY (R) **Fee:** $103.45 **Benefit:** 75% = $77.60 85% = $87.95
59709	CEREBRAL VENTRICULOGRAPHY (R) **Fee:** $89.75 **Benefit:** 75% = $67.35 85% = $76.30
59712	HYSTEROSALPINGOGRAPHY (R) **Fee:** $67.30 **Benefit:** 75% = $50.50 85% = $57.25
59715	BRONCHOGRAPHY - 1 side (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
59718	PHLEBOGRAPHY - 1 side (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
59721	SPLENOGRAPHY (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
59724	MYELOGRAPHY, 1 region (R) **Fee:** $119.65 **Benefit:** 75% = $89.75 85% = $101.75

59727	MYELOGRAPHY, 2 regions (R) **Fee:** $199.40 **Benefit:** 75% = $149.55 85% = $171.70
59730	MYELOGRAPHY, 3 regions (R) **Fee:** $267.95 **Benefit:** 75% = $201.00 85% = $240.25
59733	SIALOGRAPHY - 1 side (R) **Fee:** $67.30 **Benefit:** 75% = $50.50 85% = $57.25
59736	VASOEPIDIDYMOGRAPHY - 1 side (R) **Fee:** $67.30 **Benefit:** 75% = $50.50 85% = $57.25
59739	SINUSES AND FISTULAE (R) **Derived Fee:** The fee for the radiographic examination of the area and report plus an amount of $21.70
59742	LARYNGOGRAPHY with contrast media (R) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40
59745	PNEUMOARTHROGRAPHY (R) **Fee:** $42.40 **Benefit:** 75% = $31.80 85% = $36.05
59748	ARTHROGRAPHY - contrast (R) **Fee:** $49.85 **Benefit:** 75% = $37.40 85% = $42.40
59751	ARTHROGRAPHY - double contrast (R) **Fee:** $87.25 **Benefit:** 75% = $65.45 85% = $74.20
59754	LYMPHANGIOGRAPHY, including follow up radiography (R) **Fee:** $66.05 **Benefit:** 75% = $49.55 85% = $56.15
59757	PNEUMOMEDIASTINUM (R) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
	SUBGROUP 13 - ANGIOGRAPHY AND REPORT
	BY FILM OR OTHER TECHNIQUE
59900	SERIAL ANGIOCARDIOGRAPHY (rapid cassette changing) - each series (R) (AU 8 - 17908) **Fee:** $84.00 **Benefit:** 75% = $63.00 85% = $71.40
59903	SERIAL ANGIOCARDIOGRAPHY (SINGLE PLANE) - each series (R) (AU 8 - 17908) **Fee:** $115.65 **Benefit:** 75% = $86.75 85% = $98.35
59906	SERIAL ANGIOCARDIOGRAPHY (BI-PLANE) - each series (R) (AU 8 - 17908) **Fee:** $115.65 **Benefit:** 75% = $86.75 85% = $98.35
59912	SELECTIVE CORONARY ARTERIOGRAPHY (R) **Fee:** $305.50 **Benefit:** 75% = $229.15 85% = $277.80
59915	CEREBRAL ANGIOGRAPHY - 1 side (R) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
59918	ARTERIOGRAPHY, PERIPHERAL - 1 side (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
59921	AORTOGRAPHY (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75
59924	SELECTIVE ARTERIOGRAPHY - per injection and film or data acquisition run (R) **Fee:** $99.70 **Benefit:** 75% = $74.80 85% = $84.75

	BY DIGITAL SUBTRACTION TECHNIQUE
60000	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography, 1 to 3 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
60003	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography, 4 to 6 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
60006	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography, 7 to 9 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,060.10 **Benefit:** 75% = $795.10 85% =$1,032.40
60009	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of head and neck with or without arch aortography, 10 or more data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,241.10 **Benefit:** 75% = $930.85 85% =$1,213.40
60012	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax, 1 to 3 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
60015	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax, 4 to 6 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
60018	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax, 7 to 9 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,060.10 **Benefit:** 75% = $795.10 85% =$1,032.40
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax, 10 or more data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,241.10 **Benefit:** 75% = $930.85 85% =$1,213.40
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen, 1 to 3 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen, 4 to 6 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen, 7 to 9 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,060.10 **Benefit:** 75% = $795.10 85% =$1,032.40
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen, 10 or more data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,241.10 **Benefit:** 75% = $930.85 85% =$1,213.40
60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs, 1 to 3 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs, 4 to 6 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs, 7 to 9 data acquisition runs (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $1,060.10 **Benefit:** 75% = $795.10 85% =$1,032.40

60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs, 10 or more data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $1,241.10 **Benefit:** 75% = $930.85 85% =$1,213.40
60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs, 1 to 3 data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs, 4 to 6 data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs, 7 to 9 data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $1,060.10 **Benefit:** 75% = $795.10 85% =$1,032.40
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs, 10 or more data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $1,241.10 **Benefit:** 75% = $930.85 85% =$1,213.40
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs, 1 to 3 data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $506.80 **Benefit:** 75% = $380.10 85% = $479.10
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs, 4 to 6 data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $744.65 **Benefit:** 75% = $558.50 85% = $716.95
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs, 7 to 9 data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $1,060.10 **Benefit:** 75% = $795.10 85% =$1,032.40
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs, 10 or more data acquisition runs (R) *(See para DII. of explanatory notes to this Category)* **Fee:** $1,241.10 **Benefit:** 75% = $930.85 85% =$1,213.40
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique, 1 vessel (NR) *(See para DII. of explanatory notes to this Category)* **Fee:** $43.45 **Benefit:** 75% = $32.60 85% = $36.95
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique, 2 vessels (NR) *(See para DII. of explanatory notes to this Category)* **Fee:** $86.90 **Benefit:** 75% = $65.20 85% = $73.90
60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique, 3 or more vessels (NR) *(See para DII. of explanatory notes to this Category)* **Fee:** $130.30 **Benefit:** 75% = $97.75 85% = $110.80
	SUBGROUP 14 - TOMOGRAPHY AND REPORT
60100	TOMOGRAPHY OF ANY REGION AND REPORT (R) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
	SUBGROUP 15 - STEREOSCOPIC EXAMINATION AND REPORT
60300	STEREOSCOPIC EXAMINATION OF ANY REGION AND REPORT (R) **Derived Fee:** The fee for the radiographic examination of the area and report plus an amount of $13.05

	SUBGROUP 16 - FLUOROSCOPIC EXAMINATION AND REPORT
60500	FLUOROSCOPY, WITH GENERAL ANAESTHESIA (not being a service associated with a radiographic examination) (R) (AU 7 - 17907) **Fee:** $43.60 **Benefit:** 75% = $32.70 85% = $37.10
60503	FLUOROSCOPY, WITHOUT GENERAL ANAESTHESIA (not being a service associated with a radiographic examination) (R) **Fee:** $29.90 **Benefit:** 75% = $22.45 85% = $25.45
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Category applies (R) **Fee:** $64.10 **Benefit:** 75% = $48.10 85% = $54.50
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Category applies (R) **Fee:** $99.30 **Benefit:** 75% = $74.50 85% = $84.45
	SUBGROUP 17 - EXAMINATION NOT OTHERWISE COVERED AND REPORT
60700	RADIOGRAPHIC EXAMINATION of region and report not being a service to which another item in this Group applies (R) *(See para DIJ. of explanatory notes to this Category)* **Fee:** $20.70 **Benefit:** 75% = $15.55 85% = $17.60
	SUBGROUP 18 - PREPARATION FOR RADIOLOGICAL PROCEDURE
60900	*Note: In this Subgroup, "preparation" means the injection of opaque or contrast media or the removal of fluid and its replacement by air, oxygen or other similar preparation)* ENCEPHALOGRAPHY (NR) (AU 10 - 17910) **Fee:** $181.95 **Benefit:** 75% = $136.50 85% = $154.70
60903	CEREBRAL ANGIOGRAPHY (1 side) - percutaneous, catheter or open exposure (NR) (AU 10 - 17910) **Fee:** $128.75 **Benefit:** 75% = $96.60 85% = $109.45
60906	CEREBRAL VENTRICULOGRAPHY (NR) (AU 10 - 17910) **Fee:** $174.60 **Benefit:** 75% = $130.95 85% = $148.45
60909	DACRYOCYSTOGRAPHY - 1 side (NR) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
60912	BRONCHOGRAPHY - 1 or both sides (NR) (AU 8 - 17908) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
60915	AORTOGRAPHY (NR) (AU 8 - 17908) **Fee:** $70.90 **Benefit:** 75% = $53.20 85% = $60.30
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY - 1 vessel (NR) (AU 6 - 17906) **Fee:** $52.90 **Benefit:** 75% = $39.70 85% = $45.00
60921	SPLENOGRAPHY (NR) (AU 6 - 17906) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15
60924	RETROPERITONEAL PNEUMOGRAM (NR) **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25

60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM (NR) (AU 6 - 17906) **Fee:** $43.65 **Benefit:** 75% = $32.75 85% = $37.15
60930	PERCUTANEOUS INJECTION of radio-opaque material into RENAL CYST (including aspiration) or RENAL PELVIS for antegrade pyelography (NR) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
60933	PNEUMOARTHROGRAPHY or PNEUMOPERITONEUM (NR) **Fee:** $48.60 **Benefit:** 75% = $36.45 85% = $41.35
60936	ARTHROGRAPHY, single or double contrast, excluding arthrography of the joints between articular processes of the vertebrae (NR) **Fee:** $48.70 **Benefit:** 75% = $36.55 85% = $41.40
60939	DRIP-INFUSION PYELOGRAPHY OR CHOLEGRAPHY (NR) **Fee:** $36.55 **Benefit:** 75% = $27.45 85% = $31.10
60942	RETROGRADE MICTURATING CYSTOURETHROGRAPHY (NR) **Fee:** $68.55 **Benefit:** 75% = $51.45 85% = $58.30
60945	HYSTEROSALPINGOGRAPHY (NR) (AU 6 - 17906) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
60948	DISCOGRAPHY - 1 disc (NR) (AU 5 - 17905) **Fee:** $39.90 **Benefit:** 75% = $29.95 85% = $33.95
60951	DISCOGRAPHY using Metrizamide contrast medium (NR) **Fee:** $60.70 **Benefit:** 75% = $45.55 85% = $51.60
60954	INTRA-OSSEOUS VENOGRAPHY (NR) **Fee:** $45.30 **Benefit:** 75% = $34.00 85% = $38.55
60957	MYELOGRAPHY not being a service to which item 60960 applies (NR) (AU 11 - 17911) **Fee:** $119.65 **Benefit:** 75% = $89.75 85% = $101.75
60960	MYELOGRAPHY, using Metrizamide contrast medium (NR) (AU 11 - 17911) **Fee:** $167.00 **Benefit:** 75% = $125.25 85% = $141.95
60963	CISTERNAL PUNCTURE (NR) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
60966	SINUS OR FISTULA, INJECTION INTO (NR) **Fee:** $20.70 **Benefit:** 75% = $15.55 85% = $17.60
60969	SIALOGRAPHY (NR) **Fee:** $54.40 **Benefit:** 75% = $40.80 85% = $46.25
60972	LYMPHANGIOGRAPHY - 1 side (NR) **Fee:** $119.65 **Benefit:** 75% = $89.75 85% = $101.75
60975	LARYNGOGRAPHY (NR) **Fee:** $61.05 **Benefit:** 75% = $45.80 85% = $51.90
60978	PNEUMOMEDIASTINUM (NR) **Fee:** $78.50 **Benefit:** 75% = $58.90 85% = $66.75
60981	CHOLEGRAM (CHOLANGIOGRAM) - percutaneous transhepatic (NR) (AU 11 - 17911) **Fee:** $119.65 **Benefit:** 75% = $89.75 85% = $101.75

SUBGROUP 19 - INTERVENTIONAL TECHNIQUES

61109	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Category applies (R) **Fee:** $258.55 **Benefit:** 75% = $193.95 85% = $230.85

GROUP I5 - NUCLEAR MEDICINE IMAGING

NOTE

(This note should be read in conjunction with explanatory notes for this Category). 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 Category 1 of the Schedule where there is a request for a full medical examination accompanied by a letter or note of referral.

MYOCARDIAL PERFUSION STUDY USING THALLIUM - single study for stress *or* reperfusion (R)

61300 C	**Fee:** $367.85	**Benefit:**	75% = $275.90	85% = $340.15
61301 NC	**Fee:** $272.90	**Benefit:**	75% = $204.70	85% = $245.20

MYOCARDIAL PERFUSION STUDY USING THALLIUM - combined study for stress *and* reperfusion (R)

61304 C	**Fee:** $581.45	**Benefit:**	75% = $436.10	85% = $553.75
61305 NC	**Fee:** $433.10	**Benefit:**	75% = $324.85	85% = $405.40

MYOCARDIAL INFARCT-AVID IMAGING STUDY (R)

61308 C	**Fee:** $215.95	**Benefit:**	75% = $162.00	85% = $188.25
61309 NC	**Fee:** $161.40	**Benefit:**	75% = $121.05	85% = $137.20

GATED CARDIAC BLOOD POOL (equilibrium) STUDY (R)

61312 C	**Fee:** $249.20	**Benefit:**	75% = $186.90	85% = $221.50

GATED CARDIAC BLOOD POOL STUDY with intervention (R)

61315 C	**Fee:** $308.50	**Benefit:**	75% = $231.40	85% = $280.80

CARDIAC FIRST PASS BLOOD FLOW STUDY, CARDIAC SHUNT STUDY OR CARDIAC OUTPUT STUDY (not being a service associated with a service to which another item in this Group applies (R)

61318 C	**Fee:** $187.50	**Benefit:**	75% = $140.65	85% = $159.80
61319 NC	**Fee:** $140.00	**Benefit:**	75% = $105.00	85% = $119.00

CARDIAC FIRST PASS BLOOD FLOW STUDY, CARDIAC SHUNT STUDY OR CARDIAC OUTPUT STUDY being a service associated with a service to which another item in this Group applies (R)

61322 C	**Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $90.00

CARDIAC FIRST PASS BLOOD FLOW STUDY, CARDIAC SHUNT STUDY OR CARDIAC OUTPUT STUDY being a service associated with a service to which another item in this Group applies (R)

61323 NC	**Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $67.25

LUNG PERFUSION STUDY (R)

61326 C	**Fee:** $178.00	**Benefit:**	75% = $133.50	85% = $151.30
61327 NC	**Fee:** $132.90	**Benefit:**	75% = $99.70	85% = $113.00

LUNG VENTILATION STUDY using Xe127 gas (R)

61330 C	**Fee:** $296.65	**Benefit:**	75% = $222.50	85% = $268.95
61331 NC	**Fee:** $223.10	**Benefit:**	75% = $167.35	85% = $195.40

LUNG VENTILATION STUDY using Xe133 gas (R)

61334 C	**Fee:** $166.10	**Benefit:**	75% = $124.60	85% = $141.20
61335 NC	**Fee:** $123.40	**Benefit:**	75% = $92.55	85% = $104.90

LUNG VENTILATION STUDY using aerosol (R)

61338 C	**Fee:** $206.45	**Benefit:**	75% = $154.85	85% = $178.75
61339 NC	**Fee:** $154.25	**Benefit:**	75% = $115.70	85% = $131.15

LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using either Xe127 or Xe133 gas (R)

61342 C	**Fee:** $320.40	**Benefit:**	75% = $240.30	85% = $292.70
61343 NC	**Fee:** $237.30	**Benefit:**	75% = $178.00	85% = $209.60

NUCLEAR MEDICINE IMAGING				
	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol (R)			
61346 C	**Fee:** $356.00	**Benefit:**	75% = $267.00	85% = $328.30
61347 NC	**Fee:** $267.00	**Benefit:**	75% = $200.25	85% = $239.30
	LIVER AND SPLEEN STUDY (colloid) (R)			
61350 C	**Fee:** $211.20	**Benefit:**	75% = $158.40	85% = $183.50
61351 NC	**Fee:** $159.00	**Benefit:**	75% = $119.25	85% = $135.15
	RED BLOOD CELL SPLEEN OR LIVER STUDY (R)			
61354 C	**Fee:** $215.95	**Benefit:**	75% = $162.00	85% = $188.25
61355 NC	**Fee:** $161.40	**Benefit:**	75% = $121.05	85% = $137.20
	HEPATOBILIARY STUDY (R)			
61358 C	**Fee:** $344.10	**Benefit:**	75% = $258.10	85% = $316.40
61359 NC	**Fee:** $255.10	**Benefit:**	75% = $191.35	85% = $227.40
	BOWEL HAEMORRHAGE STUDY (R)			
61362 C	**Fee:** $397.50	**Benefit:**	75% = $298.15	85% = $369.80
61363 NC	**Fee:** $296.65	**Benefit:**	75% = $222.50	85% = $268.95
	MECKEL'S DIVERTICULUM STUDY (R)			
61366 C	**Fee:** $182.75	**Benefit:**	75% = $137.10	85% = $155.35
61367 NC	**Fee:** $137.65	**Benefit:**	75% = $103.25	85% = $117.05
	SALIVARY STUDY (R)			
61370 C	**Fee:** $182.75	**Benefit:**	75% = $137.10	85% = $155.35
61371 NC	**Fee:** $137.65	**Benefit:**	75% = $103.25	85% = $117.05
	GASTRO-OESOPHAGEAL REFLUX STUDY (R)			
61374 C	**Fee:** $391.60	**Benefit:**	75% = $293.70	85% = $363.90
61375 NC	**Fee:** $290.70	**Benefit:**	75% = $218.05	85% = $263.00
	OESOPHAGEAL CLEARANCE STUDY (R)			
61378 C	**Fee:** $117.45	**Benefit:**	75% = $88.10	85% = $99.85
61379 NC	**Fee:** $87.80	**Benefit:**	75% = $65.85	85% = $74.65
	GASTRIC EMPTYING STUDY using single tracer (R)			
61382 C	**Fee:** $581.45	**Benefit:**	75% = $436.10	85% = $553.75
	GASTRIC EMPTYING STUDY using dual tracer (R)			
61385 C	**Fee:** $622.95	**Benefit:**	75% = $467.25	85% = $595.25
	RENAL STUDY WITH OR WITHOUT DYNAMIC FLOW STUDY AND WITH OR WITHOUT COMPUTER EXTRACTION OF functional parameters (R)			
61388 C	**Fee:** $267.00	**Benefit:**	75% = $200.25	85% = $239.30
	RENAL STUDY WITH INTERVENTION (R)			
61391 C	**Fee:** $326.30	**Benefit:**	75% = $244.75	85% = $298.60
61392 NC	**Fee:** $243.25	**Benefit:**	75% = $182.45	85% = $215.55
	CYSTOURETEROGRAM (R)			
61395 C	**Fee:** $201.70	**Benefit:**	75% = $151.30	85% = $174.00
61396 NC	**Fee:** $151.90	**Benefit:**	75% = $113.95	85% = $129.15
	TESTICULAR STUDY (R)			
61399 C	**Fee:** $132.90	**Benefit:**	75% = $99.70	85% = $113.00
61400 NC	**Fee:** $99.65	**Benefit:**	75% = $74.75	85% = $84.75
	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT (R)			
61403 C	**Fee:** $180.35	**Benefit:**	75% = $135.30	85% = $153.30
61404 NC	**Fee:** $135.25	**Benefit:**	75% = $101.45	85% = $115.00
	CEREBRO-SPINAL FLUID TRANSPORT STUDY (R)			
61407 C	**Fee:** $706.00	**Benefit:**	75% = $529.50	85% = $678.30
61408 NC	**Fee:** $528.05	**Benefit:**	75% = $396.05	85% = $500.35

NUCLEAR MEDICINE IMAGING					
	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R)				
61411 C	**Fee:** $185.10	**Benefit:**	75% = $138.85	85% = $157.40	
61412 NC	**Fee:** $137.65	**Benefit:**	75% = $103.25	85% = $117.05	
	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY (not being a service associated with a service to which another item in this Group applies) (R)				
61415 C	**Fee:** $97.30	**Benefit:**	75% = $73.00	85% = $82.75	
61416 NC	**Fee:** $72.40	**Benefit:**	75% = $54.30	85% = $61.55	
	BONE STUDY - whole body (R)				
61419 C	**Fee:** $391.60	**Benefit:**	75% = $293.70	85% = $363.90	
61420 NC	**Fee:** $290.70	**Benefit:**	75% = $218.05	85% = $263.00	
	BONE STUDY - whole body and DYNAMIC BLOOD FLOW OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY (R)				
61423 C	**Fee:** $486.50	**Benefit:**	75% = $364.90	85% = $458.80	
61424 NC	**Fee:** $367.85	**Benefit:**	75% = $275.90	85% = $340.15	
	WHOLE BODY STUDY USING IODINE (R)				
61427 C	**Fee:** $444.95	**Benefit:**	75% = $333.75	85% = $417.25	
61428 NC	**Fee:** $332.25	**Benefit:**	75% = $249.20	85% = $304.55	
	WHOLE BODY STUDY USING GALLIUM (R)				
61431 C	**Fee:** $444.95	**Benefit:**	75% = $333.75	85% = $417.25	
61432 NC	**Fee:** $332.25	**Benefit:**	75% = $249.20	85% = $304.55	
	WHOLE BODY STUDY USING CELLS LABELLED WITH TECHNETIUM (R)				
61435 C	**Fee:** $397.50	**Benefit:**	75% = $298.15	85% = $369.80	
61436 NC	**Fee:** $296.65	**Benefit:**	75% = $222.50	85% = $268.95	
	BONE MARROW STUDY - whole body (R)				
61439 C	**Fee:** $391.60	**Benefit:**	75% = $293.70	85% = $363.90	
61440 NC	**Fee:** $290.70	**Benefit:**	75% = $218.05	85% = $263.00	
	REPEAT OF A WHOLE BODY STUDY on a different occasion using the same administration of radiopharmaceutical (R)				
61443 C	**Fee:** $180.35	**Benefit:**	75% = $135.30	85% = $153.30	
61444 NC	**Fee:** $135.25	**Benefit:**	75% = $101.45	85% = $115.00	
	LOCALISED BONE OR JOINT STUDY including FLOW AND BLOOD POOL STUDIES (R)				
61447 C	**Fee:** $272.90	**Benefit:**	75% = $204.70	85% = $245.20	
61448 NC	**Fee:** $204.10	**Benefit:**	75% = $153.10	85% = $176.40	
	LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY using gallium (R)				
61451 C	**Fee:** $326.30	**Benefit:**	75% = $244.75	85% = $298.60	
61452 NC	**Fee:** $243.25	**Benefit:**	75% = $182.45	85% = $215.55	
	LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY using cells labelled with technetium (R)				
61455 C	**Fee:** $278.85	**Benefit:**	75% = $209.15	85% = $251.15	
61456 NC	**Fee:** $208.85	**Benefit:**	75% = $156.65	85% = $181.15	
	REPEAT OF A LOCALISED BONE, JOINT, TUMOUR, INFECTION OR INFLAMMATION SEEKING STUDY on a different occasion using the same administration of radiopharmaceutical (R)				
61459 C	**Fee:** $121.05	**Benefit:**	75% = $90.80	85% = $102.90	
61460 NC	**Fee:** $90.20	**Benefit:**	75% = $67.65	85% = $76.70	
	VENOGRAPHY (including blood pool study, active uptake study or dynamic blood flow study) (R)				
61463 C	**Fee:** $215.95	**Benefit:**	75% = $162.00	85% = $188.25	
61464 NC	**Fee:** $161.40	**Benefit:**	75% = $121.05	85% = $137.20	
	LYMPHOSCINTIGRAPHY (R)				
61467 C	**Fee:** $278.85	**Benefit:**	75% = $209.15	85% = $251.15	
61468 NC	**Fee:** $208.85	**Benefit:**	75% = $156.65	85% = $181.15	

NUCLEAR MEDICINE IMAGING					
	THYROID STUDY (R)				
61471 C	**Fee:** $123.40	**Benefit:**	75% = $92.55	85% = $104.90	
61472 NC	**Fee:** $92.55	**Benefit:**	75% = $69.45	85% = $78.70	
	THYROID UPTAKE STUDY PERFORMED ON GAMMA CAMERA (R)				
61475 C	**Fee:** $60.50	**Benefit:**	75% = $45.40	85% = $51.45	
61476 NC	**Fee:** $45.10	**Benefit:**	75% = $33.85	85% = $38.35	
	PARATHYROID (R)				
61479 C	**Fee:** $308.50	**Benefit:**	75% = $231.40	85% = $280.80	
	ADRENAL STUDY USING SELENOCHOLESTEROL (R)				
61482 C	**Fee:** $711.95	**Benefit:**	75% = $534.00	85% = $684.25	
61483 NC	**Fee:** $533.95	**Benefit:**	75% = $400.50	85% = $506.25	
	ADRENAL STUDY (not being a service to which item 61482 or 61483 applies) (R)				
61486 C	**Fee:** $361.90	**Benefit:**	75% = $271.45	85% = $334.20	
61487 NC	**Fee:** $272.90	**Benefit:**	75% = $204.70	85% = $245.20	
	SINGLE PHOTON EMISSION TOMOGRAPHY being a service associated with a service to which another item in this Group applies (R)				
61490 C	**Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $179.95				
	TEAR DUCT STUDY (R)				
61493 C	**Fee:** $182.75	**Benefit:**	75% = $137.10	85% = $155.35	
61494 NC	**Fee:** $137.65	**Benefit:**	75% = $103.25	85% = $117.05	
	PARTICLE PERFUSION STUDY (INTRA-ARTERIAL) OR LE VEEN SHUNT STUDY (R)				
61497 C	**Fee:** $206.45	**Benefit:**	75% = $154.85	85% = $178.75	
61498 NC	**Fee:** $154.25	**Benefit:**	75% = $115.70	85% = $131.15	
	STUDY OF REGION OR ORGAN not being a service to which another item in this Group applies (R) *(See para DIK. of explanatory notes to this Category)*				
61501 C	**Fee:** $11.85	**Benefit:**	75% = $8.90	85% = $10.10	
61502 NC	**Fee:** $8.90	**Benefit:**	75% = $6.70	85% = $7.60	

INDEX TO
DIAGNOSTIC IMAGING SERVICES

*** Payable on attendance basis**

Service	Item
H	
Hand, X-ray of	57506-57515
Heart measurement (X-ray) and kymography	58515,58518
Hip joint, X-ray of	57712
Humerus, X-ray of	57506-57515
Hysterosalpingography	59712
- preparation for	60945
I	
Intraosseous venography, preparation for	60948
Intravenous cholangeography including preparation	58930
pyelography	58706,58709,58712
K	
Knee and wrist, bone age study	58300
X-ray of	57518-57527
Kymography with cardiac measurements	58515,58518
L	
Laryngography	59742
- preparation for	60975
Larynx, X-ray of	57945
Leg, X-ray of	57518-57527
Lipiodol insufflation of fallopian tubes	59712
Lumbo-sacral spine, X-ray of	58106
Lung fields, X-ray of	58500,58503,58506
Lymphangiography including follow-up radiography	59754
- preparation for	60972
M	
Malar bones, X-ray of	57912
Mammary ductogram	59306,59309
Mammography (restriction applies)	59300,59303
Mandible, X-ray of	57915
Mastoids, X-ray of	57900,57906
Maxilla, X-ray of	57912
Micturating cysto-urethrography	58721
- preparation for	60942
Myelography	59724,59727,59730
- preparation for	60957
- preparation for using Metrizamide	60960
N	
Nephrography	58700-58715
Nose, X-ray of	57921
Nuclear medicine scanning	(see below)
- cardiovascular	
cardiac blood pool study	61312,61315
cardiac blood flow, shunt/output study	61318-61323
myocardial infarct-avid imaging study	61308,61309
myocardial perfusion study, thalium	61300-61305
- central nervous	
brain study	61403,61404
cerebro spinal fluid transport study	61407,61408
cerebro spinal fluid shunt patency study	61411,61412
- endocrine	
adrenal study	61482-61487
parathyroid study	61479
thyroid study	61471,61472
thyroid uptake	61475,61476
- gastrointestinal	
bowel haemorrhage study	61362,61363
gastric emptying study	61382,61385
gastro-oesophageal reflux study	61374,61375
hepatobiliary study	61358,61359
Le Veen shunt study	61497,61498
liver and spleen study	61350,61351
Meckel's diverticulum study	61366,61367
oesophageal clearance study	61378,61379
red blood cell spleen or liver study	61354,61355
salivary study	61370,61371
spleen study	61350,61351
- genitourinary	
cystoureterogram	61395,61396
renal study	61388,61391,61392
testicular study	61399,61400
- lymphoscintigraphy	61467,61468
- pulmonary	
lung perfusion study	61326,61327
lung perfusion and ventilation study	61342-61347
lung ventilation study	61330-61339
- single photon emission tomography	61490
- skeletal	
bone marrow study	61439,61440
bone study, whole body	61419-61424
localised bone or joint study	61447,61448
localised bone/joint/tumour/infection	61451-61460
- study not otherwise covered	61501,61502
- tear duct study	61493,61494
- vascular	
dynamic flow study	61415,61416
particle perfusion study (intra-arterial)	61497,61498
regional blood volume quantitative study	61415,61416
venography	61463,61464
- whole body study	61427-61436
repeat, using same radiopharmaceutial	61443,61444
O	
Oesophagus, X-ray of	58906,58909,58912
Opaque enema	58918,58921
meal	58909,58912,58915
media, preparation for radiology	60900-60981
Orbit, X-ray of	57912
Orthopantomography	57936
P	
Palato-pharyngeal studies	57939,57942
Pelvic girdle, X-ray of	57715
Pelvimetry	59503
Pelvis, X-ray of	57715
Petrous temporal bones, X-ray of	57909
Phalanges, X-ray of	57500,57503
Phlebography	59718
- preparation for	60918,60927
Placentography	59503
Plain abdominal X-ray	58900,58903
renal X-ray	58700
Pleura, X-ray of	58500,58503
Pneumoarthrography	59745
- preparation for	60933
Pneumoencephalography	59706
- preparation for	60900
Pneumomediastinum	59757
- preparation for	60978

*** Payable on attendance basis**

* Payable on attendance basis

PATHOLOGY SERVICES

CATEGORY 6

PLEASE NOTE:

The information contained in this Category relates specifically to the Pathology Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the FOREWORD and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.

CATEGORY 6 - PATHOLOGY SERVICES

OUTLINE OF ARRANGEMENTS

EXPLANATORY NOTES

SCHEDULE OF SERVICES

CATEGORY 6 - PATHOLOGY SERVICES

OUTLINE OF ARRANGEMENTS

PA. PATHOLOGY SERVICES IN RELATION TO MEDICARE BENEFITS

PA.1 Basic Requirements

PA.1.1 *Determination of Necessity of Service*

The treating practitioner must determine that the pathology service is necessary.

PA.1.2 *Request for Service*

The service may only be provided -

(i) in response to a request from the treating practitioner or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or

(ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

PA.1.3 *Provision of Service*

The following conditions relate to provision of services:

(i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;

(ii) the service has to be provided in a pathology laboratory accredited for that kind of service;

(iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority; and

(iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided.

(v) No benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

PA.2 Exceptions to Basic Requirements

PA.2.1 *Prescribed Pathology Services*

A prescribed pathology service is a service included in Group P9 of the Pathology Schedule. Group P9 contains 11 services which may be performed by a medical practitioner in his or her own surgery on his or her own patients.

Additionally, benefit is payable only where the service is determined to be necessary by the medical practitioner rendering the service, or is in response to a request by a member of a group of practitioners to which that practitioner belongs. (See para. PO.2 for the definition of a "group of practitioners".)

PA.2.2 *Services Where Request Not Required*

A written request is not required for -

(i) a prescribed pathology service rendered by or on behalf of a medical practitioner upon his or her own patients;

(ii) a pathologist-determinable service. (A pathologist-determinable service is a pathology service determined to be necessary by an Approved Pathology Practitioner in respect of a person who is the patient of that Approved Pathology Practitioner and which is rendered by or on behalf of that Approved Pathology Practitioner. Further information on additional pathology tests not covered by a request is provided at paragraph PB.3.)

PA.3 Circumstances Where Medicare Benefits Not Attracted

PA.3.1 *Services Rendered by Disqualified Practitioner*

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

PA.3.2 *Medicare Benefits Not Payable for Certain Pathology Tests*

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- examination by animal inoculation;
- Guthrie test for phenylketonuria;
- neonatal screening for hypothyroidism (T4/TSH estimation);
- neonatal screening for Cystic Fibrosis;
- neonatal screening for Galactosemia;
- pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed; or
- any test related to the detection of the presence of human immunodeficiency virus (HIV).

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- cytotoxic food testing;
- pathology services performed for the purposes of tissue audit;
- pathology services performed for the purposes of control estimation, repeat tests (e.g. for confirmation of earlier tests on the same specimen, etc);
- preparation of autogenous vaccines;
- tissue banking and preparation procedures; or
- pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services. However, benefits will be paid for the following pathology tests:

  Item 65001 - haemoglobin estimation;
  Item 65017 - blood grouping ABO and Rh (D antigen);
  Item 65021 - examination of serum for Rh and/or other blood group antibodies.

PB. REQUESTS

PB.1 Responsibilities of Treating/Requesting Practitioners

PB.1.1 *Form of Request*

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners must be approved by the Health Insurance Commission (see paragraph PB.2). Written pathology requests from treating practitioners that are not on a form prepared and distributed by a pathologist do not need to be approved. However, all written requests for pathology services should contain the following particulars:

(i) the individual pathology services, or recognised groups of pathology tests to be rendered (see Section PQ of these notes for the list of acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;

(ii) the requesting practitioner's signature and date of request;

(iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;

(iv) the patient's name and address;

(v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service or when the specimen is obtained:

(a) a private patient in a private hospital, or approved day hospital facility;

(b) a private patient in a recognised hospital;

(c) a hospital patient in a recognised hospital;

(d) an outpatient of a recognised hospital;

(vi) details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Practitioner or an Approved Pathology Authority. If the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority. If the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

PB.1.2 ***Offence Not to Confirm an Oral Request***

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine not exceeding $1000.

PB.2 Responsibilities of Approved Pathology Practitioners

PB.2.1 ***Form of Request***

There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable, provided there are no check lists or "tick-a-box" lists of individual tests or groups of pathology services on the forms. However, pre-printed request forms issued by Approved Pathology Practitioners/Authorities for use by requesting practitioners must be approved by the Health Insurance Commission. Forms submitted for approval should be accompanied by other information or documentation such as that contained in notes for guidance, cover sheets, etc., provided to requesting practitioners.

PB.2.2 ***Offence to Provide Unapproved Request Forms***

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides (directly or indirectly) to practitioners request forms which are not approved by the Health Insurance Commission, is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine not exceeding $1000.

PB.2.3 ***Request to Approved Pathology Authority***

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

PB.2.4 ***Holding, Retention, Recording and Production of Request Forms***

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before

billing patients.

An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner is required to produce, on request from an officer of the Health Insurance Commission, no later than the end of the day following the request from the officer, a written request or written confirmation retained pursuant to the above paragraphs. The officer is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

PB.2.5 ***Offences in Relation to Retaining and Producing Request Forms***

The following offences are punishable upon conviction by a fine not exceeding $1000:

(i) an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;

(ii) an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an officer of the Health Insurance Commission before the end of the day following the day of the officer's request.

PB.2.6 ***Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner***

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

(i) where all the services are referred, he/she should forward the initial request to the second Approved Pathology Practitioner and when necessary, as mentioned in PF.1, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

(ii) where some of the services which are listed in different items in the Schedule are referred, he/she must issue his/her own request in writing listing the tests to be performed, which would show in addition to the particulars listed in paragraph PB.1.1 above:

(a) name and provider number of the original requesting practitioner; and

(b) date of initial request;

(iii) under the coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by Rule 5A entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (item 66235) are performed by two approved pathology authorities.

Although the provisions concerning designated pathology services in Rule 5A permit similar services (e.g. hormone estimations) to be performed by 2 laboratories, with different approved pathology authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the coning rules when a single laboratory performs all the estimations.

Notes:

(i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;

(ii) photocopies of requests are not acceptable;

(iii) in the case of "designated pathology services" (i.e. items 66241, 66313 and 69241 only) a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One approved pathology authority cannot claim both a PEI and a "specimen referred fee".

PB.2.7 ***Offence Not To Confirm An Oral Request***

An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine not exceeding $1000.

PB.3 Pathology Tests Not Covered by Request

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

PC. DETAILS REQUIRED ON ACCOUNTS, RECEIPTS OR ASSIGNMENT FORMS

PC.1 General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

PC.2 Approved Pathology Practitioners

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

(i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;

(ii) the name of the person to whom the service was rendered;

(iii) the date on which the service was rendered;

(iv) the name of the requesting practitioner;

(v) the date on which the request was made;

(vi) the requesting practitioner's provider number;

(vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered. Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at paragraph PQ.4 are acceptable alternatives (see paragraph PQ.1);

(viii) where the treating practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd";

(ix) provide collection centre Identification number if specimen was collected in a licensed collection centre.

Where some services have been referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details (i.e. the name and provider number of the requesting practitioner and the date of the request) to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be those of the original requesting practitioner (and not those of the first Approved Pathology Practitioner).

PC.3 Prescribed Pathology Services

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

PD. INBUILT MULTIPLE SERVICES RULE

PD.1 Description of Rule

The term "Inbuilt Multiple Services Rule" describes the arrangement whereby benefits for certain pathology tests are restricted depending on the number of services performed during a single patient episode. Patient episode is defined in paragraph PO.4 of these notes.

PD.2 Exemptions

Under Rule 3A, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 4 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 3A.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. Rule 3A.(2a) also exempts item 66217 and permits the payment of 3 separate item service fees and 3 Patient Episode Initiation fees. In order to claim the exemptions, accounts should be endorsed "Rule 3 exemption".

Note. Prothrombin time which is an automatic exemption and was previously endorsed "S4B(3)" (for exemption under section 4B(3) of the Health Insurance Act 1973) should now be endorsed "Rule 3 exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 3A, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and, the services involve substantial additional expenses for the approved pathology practitioner.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims.

PE. SCHEDULE FEES

PE.1 Single Level Fees

A single level Schedule fee as opposed to the previous SP and OP fee levels was introduced from 1 February 1992. The Schedule fee was set at 70% of the previous SP fee for all services except for a cytology item, a histopathology item and three high volume test items.

PE.2 Patient Episode Initiation Fees (PEIs)

Items in Groups P10 and P11 of the pathology services table are only applicable to services performed:

(i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and

(ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a:

(i) privately referred out-patient of a recognised hospital;

(ii) private in-patient in a recognised hospital; or where

(a) any pathology equipment of a recognised hospital, or a laboratory included in a prescribed class of laboratories, is used; or

(b) any member of the staff of a recognised hospital, or a laboratory included in a prescribed class of laboratories, participates in the provision of the service in the course of his/her employment with that hospital or laboratory.

The patient initiation fees will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders four pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one patient episode initiation fee may be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 3A or 11.(6) applies or an exemption has been granted under "S4B(3)".

Under Rule 11.(6) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

. a histopathology specimen and any other non-histopathology specimen; or

. a cytopathology specimen and any other non-cytopathology specimen.

Rule 11.(7) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient initiation fees are two-tiered.

A higher fee will be payable for specimens collected in a licensed permanent collection centre, private hospital or day hospital facility where the patient is an in-patient, the patient's residence or in a nursing home or institution. The specimen must be collected by an employee of the proprietor of the laboratory in which the pathology service will be rendered, or an Approved Pathology Practitioner associated with that laboratory.

A lower fee will be payable for specimens collected in licensed temporary collection centres, specimens collected by the patient himself or herself other than in a licensed collection centre, or specimens collected by or on behalf of a treating doctor.

PE.3 Patient Episode Initiation Fees for Certain Histopathology and Cytology Items

Histopathology Item 72801 and cytology Items 73053, 73055 and 73057 will be subject to a different patient episode initiation fee structure - Items 73901 to 73905 refer.

PE.4 Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PE.2 and PE.3:

(i) laboratories operated by the Commonwealth (these include Commonwealth health laboratories operated by the Department of Health, Housing, Local Government and Community Services as well as the laboratories operated by other Departments, e.g. the Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

(ii) laboratories operated by a State Government or authority of a State. (Laboratories operated or associated with recognised hospitals are also included);

(iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and

(iv) laboratories operated by the:

University of NSW
University of Sydney
University of New England
Monash University
University of Melbourne
University of Queensland
University of Adelaide
University of Western Australia
University of Tasmania
Australian National University.

PF. ASSIGNMENT OF MEDICARE BENEFITS

PF.1 Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at paragraph 6 of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

PF.2 Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

PG. ACCREDITED PATHOLOGY LABORATORIES

PG.1 Need For Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

PG.2 Applying For Accreditation

To become an Approved Pathology Laboratory it is necessary to lodge a completed application form with the Commonwealth Department of Health, Housing, Local Government and Community Services, PO Box 658, Woden ACT 2606. The new prescribed fees for Approved Pathology Laboratories are:

- $2500 for Category 1 labs
- $2000 for Category 2 labs
- $1500 for Category 3 labs
- $ 750 for Category 5, 6 & 7 labs.

It is also required that an application for inspection be made to an approved inspection agency. The National Association of Testing Authorities (NATA) has been chosen to act on the Commonwealth's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category 5 (general practitioner) in Victoria only.

PG.3 Effective Period of Accreditation

Accreditation takes effect from the date of approval by the Minister for Health. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

PG.4 Assessment of Applications for Accreditation

The principles of accreditation for pathology laboratories as determined by the Minister (and based on National Pathology Accreditation Advisory Council guidelines) are used to assess applications for accreditation. These take into consideration staffing, supervision, premises, etc. Copies are available from the Department of Health, Housing, Local Government and Community Services at the address given in paragraph PG.2.

PG.5 Refusal of Accreditation and Right of Review

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

PG.6 National Pathology Accreditation Advisory Council (NPAAC)

NPAAC was established in 1979. Its functions are to assist in the introduction and maintenance of uniform standards of practice in pathology services throughout Australia and to initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Commonwealth's behalf are required to conduct inspections using the standards set down by NPAAC.

PG.7 Change of Address/Location

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health. Paragraph PG.2 sets out the method for applying for accreditation.

PG.8 Change of Ownership of a Laboratory

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

PG.9 Licensed Collection Centres

To enable the payment of Medicare benefits for pathology services carried out on specimens collected in a collection centre, the centre must be licensed.

In order to be licensed, a collection centre must be owned or leased by an Approved Pathology Authority and supplied with appropriate equipment and supplies for the collection of pathology specimens. It must be staffed by employees of that Approved Pathology Authority, including staff trained in specimen collection procedures.

Collection centre licences must be applied for on an annual basis. The application forms are available from the Department of Health, Housing, Local Government and Community Services. The annual licence fee for each centre has been set at $1000.

PH. APPROVED PATHOLOGY PRACTITIONERS

PH.1 Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

PH.2 Applying for Acceptance of the Approved Pathology Practitioner Undertaking

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and

(ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration Co-ordinator, Health Insurance Commission, PO Box 9822 (in your capital city).

An application form, undertaking and associated literature can be obtained from the Pathology Registration Co-ordinator.

PH.2.1 *Payment of Acceptance Fee*

On receipt of advice that the Minister has accepted an undertaking, a cheque for $500.00 should be despatched to the Pathology Registration Co-ordinator. Applicants are required to pay this fee within 14 days of the notice being given (ie. the day the notice is sent).

As there is no discretion under the Health Insurance Act 1973 to accept late payments, failure to pay the fee within the required time means that:

(i) acceptance of the undertaking will be revoked;

(ii) a new application must be completed;

(iii) acceptance of the new undertaking cannot be backdated; and

(iv) there will therefore be a period during which Medicare benefits cannot be paid.

PH.2.2 *Reminder Process*

In administering the Approved Pathology Authority and Approved Pathology Practitioner arrangements, the Health Insurance Commission provides reminders to ensure that:

(i) applicants whose undertaking are about to expire are aware of the consequences of late lodgement; and

(ii) where the 14 day period for payment of fees is about to expire and the fees have not been paid, that applicants are aware of the consequences of failure to pay on time.

PH.3 Undertakings

PH.3.1 *Consideration of Undertakings*

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PH.3.2 *Refusal of Undertaking and Rights of Review*

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, he must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PH.3.3 *Effective Period of Undertaking*

The following applies:

(i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day the undertaking is signed. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless he considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. However, this provision does not apply when the renewal application is not received by the Health Insurance Commission until after the expiry of the existing undertaking and so under these circumstances there will be a period during which Medicare benefits cannot be paid;

(iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

PH.4 Obligations and Responsibilities of Approved Pathology Practitioners

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in paragraphs PJ, PK and PL dealing with Breaches of Undertakings, Excessive Pathology Services, and Personal Supervision.

PI. APPROVED PATHOLOGY AUTHORITIES

PI.1 Introduction

A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

PI.2 Applying for Acceptance of an Approved Pathology Authority Undertaking

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:

(i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and

(ii) a signed Approved Pathology Authority Undertaking.

to the Pathology Registration Coordinator, Health Insurance Commission, PO Box 9822 (in your capital city). Application forms, undertakings and associated literature can be obtained from the Pathology Registration Coordinator.

The application and the undertaking should be completed by the proprietor of the laboratory/ies and where the proprietor is not a natural person (e.g. company or partnership), an authorised representative/s should complete the forms. This proprietor can be:

(i) a natural person;

(ii) partners (natural persons and/or companies) in a partnership;

(iii) a body corporate (i.e. a company); or

(iv) a government authority (e.g. a public hospital).

PI.2.1 ***Payment of Acceptance Fee***

On receipt of advice that the Minister has accepted an undertaking, a cheque for $1500 should be dispatched within 14 days or the undertaking will be cancelled and the whole process begun again with a consequent gap in the payment of benefits.

PI.3 Undertakings

PI.3.1 ***Consideration of Undertakings***

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PI.3.2 ***Refusal of Undertaking and Rights of Review***

Where the Minister refuses to accept an undertaking, he must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PI.3.3 ***Effective Period of Undertaking***

The following applies:

(i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day the undertaking is signed. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;

(ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless he considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;

(iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current, and the date on which the former undertaking is to expire passes without notice of the Minister's acceptance or rejection of the new undertaking, the former undertaking remains in force until the Minister gives such notification;

(iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

PI.4 Obligations and Responsibilities of Approved Pathology Authorities

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PJ and PK dealing with Breaches of Undertakings and Excessive Pathology Services.

PJ. BREACHES OF UNDERTAKINGS

PJ.1 Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PJ.2 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

PJ.3 Appeals

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Commonwealth Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

PK. INITIATION OF EXCESSIVE PATHOLOGY SERVICES

PK.1 Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PK.2 Classes of Persons

The classes of persons are:

(i) the practitioner who initiated the services;

(ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

(iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

PK.3 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Medical Services Committee of Inquiry, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

PK.4 Appeals

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a Medical Services Committee of Inquiry. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above

procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

PL. PERSONAL SUPERVISION

PL.1 Introduction

The Health Insurance Act 1973 provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

PL.2 Extract from Undertaking

The following is an extract from the Approved Pathology Practitioner undertaking:

"PART 1 - PERSONAL SUPERVISION

1) Subject to clause 2, I undertake that where a service is rendered on my behalf, I will accept personal responsibility for the rendering of that service under the following conditions of personal supervision -

a) Where a service is rendered on my behalf, I must usually be physically available in the laboratory during the rendering of that service.

b) I may be absent from the laboratory for brief periods where the absence is due to illness or other personal exigency, or involves activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory. If such an absence occurs, and it does not exceed 7 consecutive days, then I will be regarded as continuing to personally supervise the rendering of services.

c) Where I am absent from the laboratory for more than 7 consecutive days, I must arrange for another approved pathology practitioner to personally supervise the rendering of services in the laboratory which would otherwise be rendered by me or on my behalf. Where such an arrangement is made, then I will be regarded as continuing to personally supervise the rendering of services.

d) For the purposes of the Health Insurance Act 1973, services will not be regarded as being rendered by me or on my behalf during any absence, for any reason, which occurs after I have already been absent for a total of 14 working days in any month that services are rendered.

e) If a service is being rendered on my behalf outside the normal hours of operation of the laboratory, I must be able to be contacted at the time that the service is being rendered by the person who is rendering the service. If required, I must be able to personally attend at the laboratory during the rendering of the service.

f) If a service is being rendered on my behalf by a person who is not-

i) a medical practitioner;

ii) a scientist; or

iii) a person having special qualifications or skills relevant to the service being rendered;

and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service.

g) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf.

i) all persons who render services are adequately trained;

ii) all services which are to be rendered in the laboratory are allocated to persons with appropriate qualifications and experience to render the services;

iii) the methods and procedures in operation in the laboratory for the purposes of rendering service are in accordance with proper and correct practices;

iv) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and

v) results of services and tests rendered are accurately recorded and reported.

2) Where services are to be rendered on my behalf in a laboratory:

a) where the Minister has declared, by notice in writing, that the laboratory is located in an isolated area (as defined in the principles for the approval of premises as an accredited pathology laboratory), and the Minister is satisfied that the service could not reasonably be rendered in another laboratory; or

b) which is in category 3 or 4 of the categories of accreditation;

I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of the person designated in the category of accreditation of that laboratory to supervise the rendering of the service.

3) I understand that, in relation to a laboratory which is specified in clause 2(b), the provisions of clause 2 will only apply for a period of 72 months after the commencement of section 23DB of the Health Insurance Act 1973 (1 August 1987), and that after that time the provisions of clause 1 will apply to me."

PL.3 Notes on the Above:

Part 1 of the APP Undertaking outlines the requirements for the personal supervision by an APP where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an APP of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

The only exemptions from the full requirement for personal supervision of services are for the permitted absences in clause 1 in the specific circumstances declared by the Minister (clause 2(a)) and for services provided in category 3 and 4 laboratories (clause 2(b)).

PM. DETERMINATION OF FEES FOR SERVICES OF UNUSUAL LENGTH OR COMPLEXITY

PM.1 Introduction

The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered. Section 11 of the Health Insurance Act 1973 provides that the practitioner or the patient may apply to the Health Insurance Commission for higher benefits by the fixation of a higher fee, where the person rendering the professional service considers that special consideration is warranted because of the "unusual length or complexity" of the service in the particular case. The term "unusual length or complexity" in this context refers to instances where these factors significantly exceed those usually encountered for the service listed in the Schedule.

PM.2 How to Apply

Any such application for a higher fee for any listed item in the Schedule under Section 11 of the Health Insurance Act 1973 should be made to the Health Insurance Commission and should be supported by a statement by the Approved Pathology Practitioner indicating in detail those unusual features which are the basis for the claim for a higher fee. The practitioner rendering the service should advise the patient to forward this statement with the claim form and account to the relevant Medicare office. Where the practitioner direct-bills the Health Insurance Commission, his/her statement should be attached to the assignment form.

PM.3 Statement by Practitioner

To reduce delays and to facilitate consideration of such an application, it is essential that practitioners give precise details of those unusual features of length of time, complexity and technical difficulty which might warrant approval of a higher fee. The statement should include:

(i) the time taken;

(ii) the factors which caused the undue length of time taken;

(iii) special difficulties or complexities encountered beyond those which would normally be expected in the procedure;

(iv) other significant factors.

PM.4 Referral to Pathology Services Table Committee

Generally, such applications are referred for consideration by the Pathology Services Table Committee which may recommend the payment of a higher benefit. The Committee states the principles to be followed by the Health Insurance Commission in fixing the amount of any increased fee for the service which was the subject of the application.

PM.5 Appeals

Where the Health Insurance Commission notifies a person of a decision, either, (a) that it has formed the opinion that the professional service is not of unusual length or complexity, or, (b) fixing an increased fee based on the application of principles determined by the Committee, that person may, within one month after receipt of notification of the Health Insurance Commission's decision in the matter of an increased fee, appeal to the Minister to have the decision reviewed.

The Minister will refer the appeal to the Pathology Services Table Committee for consideration. The Committee will recommend to the Minister whether the appeal should be allowed or dismissed and, if the appeal is to be allowed, determine the amount of the increased fee. If the Committee thinks fit it can formulate principles followed by the Committee in fixing that increased fee.

PN. CHANGES TO THE PATHOLOGY SERVICES TABLE

PN.1 Health Insurance Regulations

The Health Insurance Act 1973 allows the Minister for Health to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established a Committee to assist in determining changes to the Table.

This informal Committee - the Pathology Services Table Committee - comprises five representatives each from the (interested) Profession and the Commonwealth. The role of this Committee is to examine on an ongoing basis the need for changes to the structure and content of the Table including associated fees.

Any person or organisation seeking to make a submission to this Committee can contact the Secretariat at the Department using the address given at paragraph PG.2.

EXPLANATORY NOTES

PO. DEFINITIONS

PO.1 Excessive Pathology Service

This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

PO.2 Group of Practitioners

This means:

(i) a practitioner conducting a medical practice or a dental practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or

(ii) two or more practitioners conducting a medical practice or a dental practice as partners; or

(iii) those partners together with any other practitioner who participates (whether as an

employee or otherwise) in the provision of professional services as part of that practice.

PO.3 Initiate

In relation to a pathology service this means to make the decision by reason of which the service is rendered.

PO.4 Patient Episode

A patient episode refers to a pathology service specified in one or more items which is provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode.

Rule 3A provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See PD.2 and PD.3 for further information on exemptions.

Rule 11.(7) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

PO.5 Personal Supervision

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See paragraphs PL.1 to PL.3 for a full description of the responsibilities involved in personal supervision.

PO.6 Prescribed Pathology Service

These are simple basic pathology services which are included in Group P9 and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Approved Pathology Laboratory status.

PO.7 Proprietor of a Laboratory

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:

(i) the laboratory premises, whether or not the holder of an estate or interest in the premises;

(ii) the use of equipment used in the laboratory; and

(iii) the employment of staff in the laboratory.

PO.8 Specialist Pathologist

This means a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist in pathology (see paragraph 4.1 of the "General Explanatory Notes" in Section 1 of this book). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

PO.9 Designated Pathology Service

This means a pathology service specified in items 66241, 66313 or 69241. Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims either 66241, 66313 or 69241. Only the first Approved Pathology Authority can claim a "patient episode fee" while the second Approved Pathology Practitioner claims a "specimen referred fee".

PP. INTERPRETATION OF THE SCHEDULE

PP.1 Cholesterol and Triglyceride Tests (Item 66331)

It should be noted that the quantitative estimation of cholesterol and triglycerides has now been omitted from item 66201. Item 66331 has been developed to cover these tests which will be coned back to item 66201 when appropriate, i.e., where a cholesterol estimation or a triglyceride estimation or estimations for both cholesterol and triglycerides are performed (item 66331) in combination with 1 test from item 66201, the item to be claimed is 66335; item 66331 with 2 tests from item 66201, the item to be claimed is 66337; item 66331 with 3 tests from item 66201, the item to be claimed is 66339; item 66331 with 4 or more tests from item 66201, the item to be claimed is 66341. Item 66331 cannot be claimed separately if any tests from item 66201 are performed at the same time.

PP.2 Cervical and Vaginal Cytology (Items 73053 - 73057)

Item 73053 only applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. These items also apply to smears repeated due to an unsatisfactory routine smear.

Cytological examinations carried out under item 73053 should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:

(i) an examination interval of two years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or one to two years after first sexual intercourse, whichever is later.

(ii) cessation of cervical smears at 70 years for women who have had two normal results within the last five years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The Health Insurance Act excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, such as the Papanicolaou test. As there is now an established policy which has the support of the relevant professional bodies, routine screening in accordance with the policy will be regarded as good medical practice.

The screening policy will not be used as a basis for determining eligibility for benefits. However, the policy will be used as a guide for reviewing practitioner profiles.

Item 73055 applies to cervical cytological examinations where the smear has been collected for the purpose of management, follow up or investigation of a previous abnormal cytology report, or collected from women with symptoms, signs or recent history suggestive of abnormal cervical cytology.

Items 73057 applies to all vaginal cytological examinations, whether for a routine examination or for the follow up or management of a previously detected abnormal smear.

For cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, by item number, if the smear has been taken as a routine examination or for the management of a previously detected abnormality.

PQ. ABBREVIATIONS, GROUPS OF TESTS

PQ.1 Abbreviations

As stated at paragraph PC.2 of this Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in paragraph PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements are mandatory for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance.

- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

PQ.2 Tests not Listed

Tests which are not listed in the Pathology Services Schedule do not attract Medicare benefits. As explained at paragraph PN.1 of these Notes changes to the Pathology Services Schedule can only be made by the Minister for Health.

PQ.3 Audit of claims

The Health Insurance Commission is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the Health Insurance Act 1973.

PQ.4 Groups of tests

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations Included in Group	Group Abbreviation	Item Numbers
Cardiac Enzymes	Lactate dehydrogenase (LDH) Aspartate aminotransferase (AST) and Creatinine kinase (CK)	CE	66205
Coagulation Studies	Prothrombin time, activated partial thrombo-plastin time and two or more of the following tests- bleeding time, thrombin clotting time, fibrinogen degradation products, fibrin monomer, D-dimer Factor XIII screening tests.	COAG	65035
Electrolytes	Sodium (NA) Potassium (K) Chloride (CL) and Bicarbonate (HCO3)	E	66207
Lipid Studies	Cholesterol (CHOL) and Triglycerides (TRIG)	FATS	66203
Liver Function Tests	Alkaline phosphatase (ALP), Alanine aminotransferase (ALT), Aspartate aminotransferase (AST), Albumin (ALB), Bilirubin (BIL),	LFT	66211

	Gamma glutamyl transpeptidase (GGT), Lactate dehydrogenase (LDH), and Protein (PROT).		
Syphilis Serology	Rapid plasma reagin test (RPR) or venereal disease research laboratory test (VDRL) and Treponema pallidum haemagglutin test (TPHA) or Fluorescent treponemal antibody-absorption test (FTA)	STS	69231
Urea, Electrolytes, Creatinine	Urea, Electrolytes, Creatinine	U&E	66211

PX. PATHOLOGY SERVICES TABLE

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

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

"approved pathology authority" has the same meaning as in Division 4A of Part 11A of the Act;

"patient episode" means:

(a) a pathology service to which Rule 3A refers that is provided in the circumstances described in that rule that relate to the service; and

(b) except in the case of a pathology service to which paragraph (a) refers - a pathology service or pathology services, whether specified in a single item or in 2 or more items, provided for a single patient whose need for the service or services was determined under subsection 16A(1) of the Act on the same day, whether rendered by an approved pathology practitioner or more than 1 approved pathology practitioner on the same day or on different days;

"recognised pathologist" means a medical practitioner recognised as a specialist in pathology under a determination under subsection 61(3) of the Act;

"the Act" means the Health Insurance Act 1973.

(2) In these Rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A(6) of the Act applies.

(3) Unless the contrary intention appears, a reference in this table by number to an item that is not included in this table is a reference to a correspondingly numbered item in the general services table or the diagnostic imaging services table, as each case requires.

2. (1) If a service is described:

(a) in an item in general terms; and

(b) in another item in specific terms;

only the item that describes the service in specific terms applies to the service.

(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.

(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.

3. (1) In subrule (2), **"service"** includes an assay, estimation and test.

(2) Subject to Rule 3A, 2 or more pathology services rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:

(a) the services are listed in the same item; and

(b) the patient's need for the services was determined under subsection 16A(1) of the Act on the same day even if they are rendered by an approved pathology practitioner on more than one day.

3A.(1) Rule 3 does not apply to:

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

(b) the quantitative estimation of 1 or more fractions of neonatal bilirubin, specified in item 66273;

if:

(c) the service is rendered in relation to a single specimen taken on each of not more than 4 occasions in a period of 24 hours; and

(d) the service is rendered to a patient in a hospital unit where:

(i) the presence of 1 nurse is required for each group of not more than 4 patients; and

(ii) the condition of the patients is continuously observed in relevant respects; and

(e) in order to render the service, an approved pathology practitioner who is a recognised pathologist has to arrange for a member of the laboratory staff of the approved pathology authority concerned to undertake duties in respect of the service that are in addition to the usual duties of the staff member.

(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:

(a) estimation of prothrombin time in respect of a patient undergoing anticoagulant therapy;

(b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;

(c) a service specified in item 65007 in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;

(d) a service specified in item 65007 in relation to methotrexate, gold or penicillamine therapy of a patient;

(e) a service specified in item 66201 in relation to methotrexate therapy of a patient;

(f) quantitative estimation of urea, creatinine and electrolytes in relation to:

(i) cis-platinum therapy of a patient; or

(ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital.

(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.

(3) This Rule does not apply in relation to a pathology service unless the account for fees in respect of the service is endorsed with the words 'Rule 3 Exemption'.

4. If:

(a) a pathology service to which an item of the table applies is rendered for a patient in accordance with a request; and

(b) another pathology service is rendered for the patient in accordance with the request; and

(c) an item of the table:

(i) applies to the other service; and

(ii) is referred to in the item mentioned in paragraph (a);

the other service is treated as if it were part of the service referred to in paragraph (a).

Example:

The requesting doctor requests an extended blood grouping test (covered by item 65019) and the test includes a basic blood grouping test (covered by item 65017). Item 65017 is referred to in item 65019. Benefit is payable under item 65019 for the extended blood grouping test but benefit is not payable separately under item 65017 for the basic blood grouping test.

5. For the purposes of items 65001 to 66200 (inclusive):

(a) if pathology services of a kind referred to in item 65017 or 65019 are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during that period; and

(b) tests (except the tests mentioned in item 65023) carried out on material stored from a previous patient episode in response to a later request are treated as part of that previous patient episode if the second request is made within 14 days of that previous patient episode.

5A.(1) In this Rule:

"designated pathology service" means a pathology service specified in items 66241, 66389, 66403 or 69241.

(2) Subject to subrule (3), if an approved pathology practitioner in an approved pathology authority :

(a) has been requested to render a pathology service that specifies 2 or more estimations comprising a designated pathology service; and

(b) is unable to perform 1 or more, but not all, of the estimations because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority in relation to that estimation or those estimations; and

(c) requests an approved pathology practitioner in another approved pathology authority to render 1 or more, but not all, of the estimations;

the service rendered by the second practitioner is taken to be the designated pathology service.

(3) Items 73901 to 73917 (inclusive) do not apply to the second-mentioned approved pathology practitioner in subrule (2).

6. For the purposes of items 66201 to 69200 (inclusive):

(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

(b) tests carried out on material stored from a previous patient episode in response to a later request are treated as part of that previous patient episode if the second request is made within 14 days of that previous patient episode.

7. For the purposes of items 69201 to 71000 (inclusive):

(a) **"serial examinations or cultures"** means examinations or cultures requested on 1 occasion whether or not:

(i) the materials are received on different days by the approved pathology practitioner; or

(ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and

(b) tests carried out on material stored from a previous patient episode in response to a later request are treated as part of that previous patient episode if the second request occurs within 14 days of that previous patient episode.

8. For the purposes of items 71001 to 72800 (inclusive):

(a) in items 71119, 71121, 71123, and 71125 the estimation of a single antibody includes qualitative and quantitative assays for that antibody; and

(b) tests carried out on material stored from a previous patient episode in response to a later request are treated as part of that previous patient episode if the second request occurs within 14 days of that previous patient episode.

9. For the purposes of items 72801 to 73040 (inclusive):

(a) **"biopsy material"** means all tissue received by the approved pathology practitioner from an operation, or a group of operations, performed on a patient at the same time, other than a bone marrow biopsy; and

(b) if:

(i) a pathology service that is the examination of biopsy material is rendered under any of those items; and

(ii) a further pathology service mentioned in any of those items is also rendered using that biopsy material;

those pathology services are treated as 1 pathology service.

10. For the purposes of items 73041 to 73280 (inclusive),

"serial examinations" means examinations requested on 1 occasion whether or not:

(a) the materials are received on different days by the approved pathology practitioner; or

(b) the examinations were requested on 1 or more request forms by the treating practitioner.

11.(1) For the purposes of this rule and items 73901 to 73921 (inclusive):

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

(a) disadvantaged children; or

(b) juvenile offenders; or

(c) aged persons; or

(d) chronically ill psychiatric patients; or

(e) homeless persons; or

(f) unemployed persons; or

(g) persons suffering from alcoholism; or

(h) persons addicted to drugs; or

(i) physically or mentally handicapped persons.

"licensed collection centre" has the same meaning as in Part IIA of the Act;

"prescribed laboratory" means a laboratory operated by:

(a) the Commonwealth; or

(b) a State; or

(c) an authority of a State or Territory; or

(d) the Northern Territory; or

(e) the Australian Capital Territory; or

(f) an Australian tertiary education institution.

"specimen collection centre" has the same meaning as in Part IIA of the Act;

"treating practitioner" has the same meaning as in paragraph 16A(1)(a) of the Act.

(2) A service mentioned in items 73901 to 73921 inclusive) applies to a pathology service when rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist unless:

(a) the service is rendered upon a request made in the course of an out-patient service at a recognised hospital; or

(b) the service is rendered upon a request made for a patient who is a private patient in a recognised hospital when the request was made; or

(c) the pathology equipment of a recognised hospital, or prescribed laboratory, is used in rendering the service; or

(d) a member of the staff of a recognised hospital, or prescribed laboratory, participates in the service in the course of the member's employment with the hospital or laboratory.

(3) A service mentioned in items 73901 to 73921 (inclusive), does not apply to a pathology service:

(a) to which 16A (7) of the Act applies: or

(b) unless at least one of the items 65001 to 73529 (inclusive) also applies to that service.

(4) Subject to subrule (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.

(5) Item 73921:

(a) applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.

(6) 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.

(7) 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.

11A. If item 73921 applies to a patient episode, none of items 73901 to 73917 (inclusive) applies to any pathology service rendered by the approved pathology authority or the approved pathology provider in respect of that patient episode.

12. The abbreviations at the end of the table may be used to identify particular pathology services or groups of pathology services.

GROUP P1 - HAEMATOLOGY

65001	Blood count consisting of erythrocyte count, C-reactive protein, erythrocyte sedimentation rate, blood viscosity, haematocrit, haemoglobin, platelet count, leucocyte count, reticulocyte count - 1 or 2 procedures **Fee:** $5.60 **Benefit:** 75% = $4.20 85% = $4.80
65003	3 or more procedures to which item 65001 applies, including any calculation or measurement of erythrocyte or other indices **Fee:** $7.65 **Benefit:** 75% = $5.75 85% = $6.55
65005	Examination of blood film, with or without 5 part differential cell count, or 5 part differential cell count with or without examination of blood film, and if performed, any of these additional services - Direct Coombs test, tests for heterophile antibodies, cold agglutinins, examination of blood film by special stains to demonstrate Heinz bodies, parasites or iron, or examination of a blood film with alpha-naphthyl acetate esterase, choloroacetate esterase, neutrophil alkaline phosphatase, nitroblue tetrazolium, periodic acid Schiff, Sudan Black stains, or Kleihauer test for HbF on blood film, including any services specified in item 65027 **Fee:** $10.10 **Benefit:** 75% = $7.60 85% = $8.60
65007	Full blood examination consisting of items 65003 and 65005 **Fee:** $17.50 **Benefit:** 75% = $13.15 85% = $14.90
65009	Erythrocytes, qualitative or quantitative assessment of haemolysis or metabolic enzymes by - erythrocyte autohaemolysis test, erythrocyte fragility test, sugar water test, erythrocyte metabolic enzyme test, heat denaturation test, isopropanol precipitation test, acid haemolysis test, and quantitation of muramidase in serum or urine - 1 or more procedures **Fee:** $23.30 **Benefit:** 75% = $17.50 85% = $19.85
65011	Tests for the diagnosis of haemoglobinopathy consisting of haemoglobin electrophoresis and 2 of the following - examination for HbH, quantitation of HbA2 or HbF, including any services specified in items 65001, 65003, 65005, and 65007 **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
65013	Histopathological examination of sections of bone marrow trephine biopsy including where indicated, examination of marrow smears and any special stains and immunochemical techniques, including any services specified in items 65001, 65003, 65005, 65007 and 65015 **Fee:** $111.50 **Benefit:** 75% = $83.65 85% = $94.80
65015	Bone marrow examination of aspirated material including any special stains, immunochemical techniques and clot sections where necessary, including any services specified in items 65001, 65003, 65005 and 65007 **Fee:** $80.95 **Benefit:** 75% = $60.75 85% = $68.85
65017	Blood grouping, including back-grouping when performed - ABO and Rh (D antigen) **Fee:** $9.80 **Benefit:** 75% = $7.35 85% = $8.35
65019	Blood grouping - Rh phenotypes, Kell system, Duffy system, M and N factors or any other blood group system - 1 or more systems, including any services specified in item 65017 **Fee:** $19.50 **Benefit:** 75% = $14.65 85% = $16.60
65021	Blood grouping, including back-grouping when performed, and examination of serum for Rh and other blood group antibodies, including identification and quantitative estimation of any antibodies detected, and including any services specified in items 65001, 65003, 65005 and 65007 **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
65023	Compatibility testing, including all necessary grouping checks of patient and donor, examination for antibodies, identification and, if necessary, quantitative estimation of any antibodies detected and any services specified in items 65001, 65003, 65005, 65007, 65017 and 65021 including all testing performed on any 1 day **Fee:** $88.60 **Benefit:** 75% = $66.45 85% = $75.35
65025	Examination of serum for blood group antibodies including identification and, if necessary, quantitative estimation of any antibodies detected **Fee:** $16.05 **Benefit:** 75% = $12.05 85% = $13.65
65027	Direct Coombs test, qualitative or quantitative test for cold agglutinins, or heterophile antibodies, qualitative spectroscopic examination of blood for abnormal haemoglobins, qualitative test for red cell porphyrins and detection of metalbumin (Schumm's test) including those services specified in items 65005 and 65007 - 1 or more tests **Fee:** $8.85 **Benefit:** 75% = $6.65 85% = $7.55

65029	Skin bleeding time, coagulation time, prothrombin time, activated partial thromboplastin time, thrombin time (including test for presence of an inhibitor and serial tests for fibrinolysis), test for factor XIII deficiency, fibrinogen, or 1 of - fibrinogen degradation products, fibrin monomer or D-dimer - 1 estimation **Fee:** $12.25 **Benefit:** 75% = $9.20 85% = $10.45
65031	2 estimations specified in item 65029 **Fee:** $16.20 **Benefit:** 75% = $12.15 85% = $13.80
65033	3 estimations specified in item 65029 **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
65035	4 or more estimations specified in item 65029 **Fee:** $24.10 **Benefit:** 75% = $18.10 85% = $20.50
65037	Quantitative assay, by 1 or more techniques, of plasminogen, antithrombin III, Protein C, Protein S, heparin cofactor II, euglobulin clot lysis time and test for lupus anticoagulant - 1 estimation **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45
65039	4 or more estimations specified in item 65037 **Fee:** $76.40 **Benefit:** 75% = $57.30 85% = $64.95
65041	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or similar substance - 1 or more estimations **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
65043	Heparin assay, only when monitoring a patient on subcutaneous heparin or low molecular weight heparin - 1 or more estimations **Fee:** $32.10 **Benefit:** 75% = $24.10 85% = $27.30
65045	Quantitative assay of Von Willebrand's factor antigen (factor VIII related antigen), Von Willebrand's factor (ristocetin cofactor), factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, Passovy factor - 1 estimation **Fee:** $32.05 **Benefit:** 75% = $24.05 85% = $27.25
65047	2 estimations specified in item 65045 **Fee:** $46.20 **Benefit:** 75% = $34.65 85% = $39.30
65049	3 or more estimations specified in item 65045 **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30

GROUP P2 - CHEMICAL

‡ 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 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:** $9.90 **Benefit:** 75% = $7.45 85% = $8.45
66203	2 estimations specified in item 66201 **Fee:** $11.95 **Benefit:** 75% = $9.00 85% = $10.20
66205	3 estimations specified in item 66201 **Fee:** $14.00 **Benefit:** 75% = $10.50 85% = $11.90
66207	4 estimations specified in item 66201 **Fee:** $16.05 **Benefit:** 75% = $12.05 85% = $13.65
66209	5 estimations specified in item 66201 **Fee:** $18.10 **Benefit:** 75% = $13.60 85% = $15.40
66211	6 or more estimations specified in item 66201 **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
66213	Qualitative estimation by any method, except by reagent strip or dip-stick of the following urine constituents - bilirubin, cystine (cysteine), haemoglobin, melanin (melanogen), myoglobin, porphobilinogen, porphyrins, urobilinogen or pH measurement of body fluids other than urine (excepting urine acidification test), or cryoglobulins or cryofibrinogen in plasma - 1 or more estimations **Fee:** $9.60 **Benefit:** 75% = $7.20 85% = $8.20
66215	Quantitative estimation of cryoglobulins or cryofibrinogen after a positive result for cryoglobulin is obtained in any service specified in item 66213 (including provision of that service) - 1 or more estimations **Fee:** $14.50 **Benefit:** 75% = $10.90 85% = $12.35
66217	Qualitative estimation by any method except by reagent strip or dip-stick of the following faecal constituents - haemoglobin, porphyrins, reducing substances - each estimation, to a maximum of 3 estimations, taken on separate days **Fee:** $6.40 **Benefit:** 75% = $4.80 85% = $5.45
66219	Immunological detection of human haemoglobin in faeces, including any additional services specified in item 66217 - 1 estimation in any 28 day period **Fee:** $12.20 **Benefit:** 75% = $9.15 85% = $10.40
66223	Osmolality, estimation by osmometer, in serum or in urine - 1 or more estimations **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45
66225	Quantitative estimation of blood gases including tests performed from - pO_2, oxygen saturation, pCO_2, bicarbonate, pH, and any other measurement (eg. haemoglobin, potassium) or calculation performed on the same specimen - 1 or more estimations on 1 specimen **Fee:** $32.85 **Benefit:** 75% = $24.65 85% = $27.95
66227	Estimation of blood gases as specified in item 66225 on each specimen in excess of 1 to a maximum of 6 specimens within any 1 day **Fee:** $8.70 **Benefit:** 75% = $6.55 85% = $7.40
66229	Calculus, analysis of 1 or more **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35

‡ 66231	Drug or chemical assays - including all qualitative and quantitative tests on blood, urine or other body fluid for a drug or drugs of abuse, including illegal drugs and legally available drugs taken other than in appropriate dosage, ingested or absorbed toxic chemicals including any services specified in items 66235, 66237 and 66239, but excluding the surveillance of sports people and athletes for performance improving substances or the monitoring of patients participating in a drug abuse treatment program **Fee:** $40.50 **Benefit:** 75% = $30.40 85% = $34.45
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:** $20.20 **Benefit:** 75% = $15.15 85% = $17.20
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:** $28.30 **Benefit:** 75% = $21.25 85% = $24.10
66239	3 or more estimations specified in item 66235 **Fee:** $36.40 **Benefit:** 75% = $27.30 85% = $30.95
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:** $8.10 **Benefit:** 75% = $6.10 85% = $6.90
66243	Amniotic fluid, spectrophotometric examination of, estimation of lecithin/sphingomyelin ratio, palmitic acid, phosphatidylglycerol or lamellar body phospholipid - 1 or more examinations or estimations **Fee:** $32.10 **Benefit:** 75% = $24.10 85% = $27.30
66245	Electrophoresis, quantitative or qualitative of serum, urine or other body fluid to demonstrate protein classes or presence and amount of paraprotein, or the isoenzymes of lactate dehydrogenase, alkaline phosphatase and creatine kinase or lipoprotein electrophoresis (only when the cholesterol is >6.5 mmol/l and triglyceride >3.0 mmol/l or in the diagnosis of types III and IV hyperlipidaemia), including the preliminary quantitation of total protein, albumin and globulin or of total relevant enzyme activity - 1 examination to a maximum of 2 examinations in any 12 month period **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35
66247	Electrophoresis, quantitative or qualitative of concurrently collected, or collected within a 28 day period, serum, urine or other body fluid to demonstrate protein classes or presence and amount of paraprotein, including the preliminary quantitation of total protein, albumin and globulin, or of total relevant enzyme activity - 2 or more examinations **Fee:** $44.30 **Benefit:** 75% = $33.25 85% = $37.70
66255	Alpha-1-acid glycoprotein, alpha-1-antitrypsin, alpha-2-macroglobulin, quantitative estimation in serum, urine or other body fluid - 1 or more estimations **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
66257	C-1 esterase inhibitor, quantitative estimation **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
66258	C-1 esterase inhibitor, functional assay **Fee:** $43.95 **Benefit:** 75% = $33.00 85% = $37.40
66261	CA-125 antigen, CA-15.3 antigen, CA-19.9 antigen, carcinoembryonic antigen (CEA), mammary serum antigen, mucin-like carcinoma associated antigen (1 or more fractions), neuron-specific enolase, thyroglobulin in serum or other body fluid, in the monitoring or confirmation of malignancy, quantitative estimation - 1 estimation **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
66262	2 or more estimations specified in item 66261 **Fee:** $36.20 **Benefit:** 75% = $27.15 85% = $30.80

66263	Iron studies consisting of quantitative analysis of iron, transferrin or iron binding capacity and ferritin **Fee:** $38.20 **Benefit:** 75% = $28.65 85% = $32.50
66265	Serum B12, serum folate - 1 or more estimations within any 28 day period **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45
66267	Red cell folate and serum B12 and, if required, serum folate, to a maximum of 3 estimations in any 12 month period **Fee:** $43.90 **Benefit:** 75% = $32.95 85% = $37.35
66269	Vitamins, quantitative estimation in blood, urine or other body fluid, by direct or indirect means, of vitamins A, B1, B2, B3, B6, C, and E - 1 or more estimations within any 6 month period **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35
66271	Vitamin D or D fractions - 1 or more estimations **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35
66277	Aluminium (except if item 66325 applies), arsenic, beryllium, cadmium, copper, chromium, gold, manganese, mercury, nickel, selenium, strontium, in blood, urine or other body fluid or tissue - 1 or more estimations in any 6 month period **Fee:** $34.90 **Benefit:** 75% = $26.20 85% = $29.70
66279	Blood lead estimation, other than for occupational health screening purposes, to a maximum of 3 estimations in any 6 month period - each estimation **Fee:** $29.80 **Benefit:** 75% = $22.35 85% = $25.35
66281	Porphyrins (1 or more fractions), catecholamines (1 or more fractions), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) - quantitative including any qualitative estimations - 1 or more estimations **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15
66283	Faecal fat, breath hydrogen measurements in response to loading with disaccharides - 1 or more quantitative estimations within any 28 day period **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15
66285	Solid tissue or tissues excluding blood elements - assay of 1 or 2 enzymes **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15
66287	Assay of 3 to 5 enzymes specified in item 66285 **Fee:** $72.55 **Benefit:** 75% = $54.45 85% = $61.70
66289	Assay of 6 or more enzymes specified in item 66285 **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
66291	Thyroid function tests, including thyrotrophin (TSH) and at least 1 or more of the following tests - free thyroxine index, free thyroxine, free T3, total T3, thyroxine binding globulin **Fee:** $40.50 **Benefit:** 75% = $30.40 85% = $34.45
66293	Thyrotrophin releasing hormone (TRH) test, including provision and administration of TRH and all necessary estimations of hormones **Fee:** $48.10 **Benefit:** 75% = $36.10 85% = $40.90
66295	Growth hormone suppression by glucose loading, growth hormone stimulation by exercise, dexamethasone suppression test, L-dopa stimulation of growth hormone, where physically performed by a recognised pathologist - 1 or more procedures **Fee:** $11.45 **Benefit:** 75% = $8.60 85% = $9.75
66297	Gonadotrophin releasing hormone stimulation test, synacthen stimulation test, glucagon stimulation test with C-peptide measurement, pentagastrin stimulation of thyrocalcitonin release, secretin stimulation of gastrin release, insulin hypoglycaemia, arginine infusion, where physically performed by a recognised pathologist - 1 procedure **Fee:** $38.20 **Benefit:** 75% = $28.65 85% = $32.50
66299	2 or more tests specified in item 66297 **Fee:** $61.10 **Benefit:** 75% = $45.85 85% = $51.95
66315	Hormone receptor assay on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more assays **Fee:** $77.90 **Benefit:** 75% = $58.45 85% = $66.25

‡ 66317	HDL cholesterol or apolipoprotein B/A1 ratio, estimation of, in patients with serum cholesterol >5.5mmol/l or those on prescribed lipid lowering drugs or with a fasting serum triglyceride level > 2.0 mmol/1 - each episode to a maximum of 4 episodes in any 12 month period **Fee:** $12.20 **Benefit:** 75% = $9.15 85% = $10.40
66319	Glycosylated haemoglobin only when performed in the management of established diabetes - each estimation to a maximum of 4 estimations in any 12 month period **Fee:** $16.40 **Benefit:** 75% = $12.30 85% = $13.95
66321	Quantitative estimation in the 2nd trimester of pregnancy of alpha-fetoprotein, human chorionic gonadotrophin and oestriol and any other substance to detect foetal abnormality, including any service specified in 1 or more of items 66259, 66301, 73527 or 73529 - 1 patient episode in that pregnancy **Fee:** $53.80 **Benefit:** 75% = $40.35 85% = $45.75
66323	Estimation of tryptic activity in faeces for the investigation of diarrhoea of greater than 4 weeks duration in children less than 6 years of age **Fee:** $10.85 **Benefit:** 75% = $8.15 85% = $9.25
66325	Estimation of serum aluminium in a patient in a renal dialysis program - each estimation **Fee:** $34.90 **Benefit:** 75% = $26.20 85% = $29.70
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:** $11.75 **Benefit:** 75% = $8.85 85% = $10.00
66335	Services specified in item 66331 and 1 estimation specified in item 66201 **Fee:** $14.00 **Benefit:** 75% = $10.50 85% = $11.90
66337	Services specified in item 66331 and 2 estimations specified in item 66201 **Fee:** $16.05 **Benefit:** 75% = $12.05 85% = $13.65
66339	Services specified in item 66331 and 3 estimations specified in item 66201 **Fee:** $18.10 **Benefit:** 75% = $13.60 85% = $15.40
66341	Services specified in item 66331 and 4 or more estimations specified in item 66201 **Fee:** $20.15 **Benefit:** 75% = $15.15 85% = $17.15
66343	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:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
† 66353	Alpha-fetoprotein (where not requested as part of item 66321) - quantitative estimation in serum or other body fluids **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
† 66355	Ferritin (where not requested as part of iron studies) - quantitative estimation **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
† 66357	Prostate specific antigen, prostatic acid phosphatase, in the monitoring or confirmation of malignancy - quantitative estimation - 1 estimation **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
† 66359	2 estimations specified in item 66357 **Fee:** $36.20 **Benefit:** 75% = $27.15 85% = $30.80
† 66361	Beta-2-microglobulin, caeruloplasmin, haptoglobulins, microalbumin in proven diabetes mellitus, prealbumin - quantitative estimation in serum, urine or other body fluids - 1 estimation **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
† 66363	2 or more estimations specified in item 66361 **Fee:** $36.20 **Benefit:** 75% = $27.15 85% = $30.80
† 66365	Neonatal bilirubin (1 or more fractions) - quantitative estimation **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45

† 66367	Acetoacetate, alcohol, amino acids, ammonia, angiotensin converting enzyme, beta-hydroxybutyrate, cholinesterase, cysteine, total free fatty acids, histamine, hydroxyindoleacetic acid, hydroxyproline, lactate, oxalate, pyruvate, serotonin, xylose, zinc - 1 quantitative estimation **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45
† 66369	2 or more estimations specified in item 66367 **Fee:** $37.80 **Benefit:** 75% = $28.35 85% = $32.15
† 66371	TSH (where not requested as part of thyroid function test or in association with other hormones or hormone binding proteins specified in item 66377) - quantitative estimation **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
† 66373	Human placental lactogen, oestriol (where not requested as part of item 66321 - quantitative estimation by any method - 1 estimation **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
† 66375	2 estimations specified in item 66373 **Fee:** $42.05 **Benefit:** 75% = $31.55 85% = $35.75
† 66377	Hormones and hormone binding proteins, quantitative estimation by any method of - androstenedione, DHEAS, dihydrotestosterone, FSH, hydroxyprogesterone, LH, oestradiol, oestrone, progesterone, prolactin, sex hormone binding globulin, free or total testosterone, TSH (where it is not requested on its own or as part of a thyroid function test) - 1 estimation **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50
† 66379	2 estimations specified in item 66377 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 2 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $42.05 **Benefit:** 75% = $31.55 85% = $35.75
† 66381	3 estimations specified in item 66377 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 3 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $52.95 **Benefit:** 75% = $39.75 85% = $45.05
† 66383	4 estimations specified in item 66377 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 4 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $63.85 **Benefit:** 75% = $47.90 85% = $54.30
† 66385	5 estimations specified in item 66377 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 5 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $74.75 **Benefit:** 75% = $56.10 85% = $63.55
† 66387	6 or more estimations specified in item 66377 **Fee:** $85.65 **Benefit:** 75% = $64.25 85% = $72.85
† 66389	Estimations specified in any of items 66377 to 66387 (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 tests specified on the request form. The PEI applicable to this item is 73921, the "Specimen Referred Fee".) **Fee:** $10.90 **Benefit:** 75% = $8.20 85% = $9.30
† 66391	Hormones and hormone binding proteins, quantitative estimation by any method of - ACTH, aldosterone, C-peptide, calcitonin, cortisol, cyclic AMP, 11-deoxycortisol, gastrin, glucagon, growth hormone, insulin, PTH, renin, somatomedin C(IgF1), urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (anti-diuretic hormone) - 1 estimation **Fee:** $31.15 **Benefit:** 75% = $23.40 85% = $26.50

† 66393	2 estimations specified in item 66391 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 2 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $42.05 **Benefit:** 75% = $31.55 85% = $35.75
† 66395	3 estimations specified in item 66391 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 3 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $52.95 **Benefit:** 75% = $39.75 85% = $45.05
† 66397	4 estimations specified in item 66391 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 4 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $63.85 **Benefit:** 75% = $47.90 85% = $54.30
† 66399	5 estimations specified in item 66391 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 5 of the tests specified on the request form and refers the remainder to the laboratory of a separate APA.) **Fee:** $74.75 **Benefit:** 75% = $56.10 85% = $63.55
† 66401	6 or more estimations specified in item 66391 **Fee:** $85.65 **Benefit:** 75% = $64.25 85% = $72.85
† 66403	Estimations specified in any of items 66391 to 66401 (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 tests specified on the request form. The PEI applicable to this item is 73921, the "Specimen Referred Fee".) **Fee:** $10.90 **Benefit:** 75% = $8.20 85% = $9.30

GROUP P3 - MICROBIOLOGY

69201	Microscopic examination of material other than blood, from 1 or more sites, obtained directly from a patient and excluding material from cultures - wet film, including differential cell count if performed, examination for dermatophytes or dark ground illumination, or stained preparation or preparations using any relevant stain or stains - 1 or more examinations **Fee:** $7.25 **Benefit:** 75% = $5.45 85% = $6.20
69203	Microscopic examination of faeces for parasites using concentration techniques including the use of appropriate stains, to a maximum of 3 estimations taken on separate days including any services specified in item 69201 - each estimation **Fee:** $12.20 **Benefit:** 75% = $9.15 85% = $10.40
69205	The cultural examination and microscopical examination when indicated (including the detection of antigens not elsewhere specified in the Schedule) to determine the presence of pathogenic micro-organisms, including fungi but excluding viruses, from nasal swabs, throat swabs, eye swabs and ear swabs, including pathogen identification and antibiotic sensitivity testing, including any services specified in item 69201 - 1 or more sites **Fee:** $19.10 **Benefit:** 75% = $14.35 85% = $16.25
‡ 69207	Microscopical and cultural examination (including the detection of antigens not elsewhere specified in the Schedule) to determine the presence of pathogenic micro-organisms, including fungi but excluding viruses, from the following sites - skin or other superficial sites, urethra, vagina, cervix or rectum (except for faecal pathogens), or specimens of sputum (except when part of item 69213), including pathogenic identification and antibiotic sensitivity testing, including any services specified in items 69201, 69205 and 73810 - 1 or more examinations on 1 or more specimens **Fee:** $27.90 **Benefit:** 75% = $20.95 85% = $23.75
69209	Microscopical and cultural examination (including the detection of antigens not elsewhere specified in the Schedule) of postoperative wounds, aspirations of body cavities, synovial fluid, CSF and operative or biopsy specimens for the presence of pathogenic micro-organisms, including fungi but excluding viruses, involving aerobic and anaerobic culture and the use of different culture media and including pathogen identification and antibiotic sensitivity testing, including any services specified in items 69201, 69205 and 69207 - 1 or more sites **Fee:** $37.80 **Benefit:** 75% = $28.35 85% = $32.15
69211	Cultural examination (including the detection of clostridial toxins or antigens not elsewhere specified in the Schedule) of faeces to determine the presence or absence of faecal pathogens, involving the use of at least 2 selective or enrichment media as well as culture in at least 2 different atmospheres and includes pathogen identification and antibiotic sensitivity testing, including any services specified in item 69201, to a maximum of 3 specimens in any 7 day period - each examination **Fee:** $45.85 **Benefit:** 75% = $34.40 85% = $39.00
69213	Microscopy with appropriate stains and cultural examinations of 3 specimens of sputum, urine or other bodily fluids for mycobacteria and any other bacterial pathogens, including pathogen identification and antibiotic sensitivity testing and including any services specified in item 69201 **Fee:** $64.15 **Benefit:** 75% = $48.15 85% = $54.55
69215	Blood culture to determine the presence or absence of pathogenic micro-organisms excluding viruses, including serial cultures and sub-cultures, any relevant cultural methods and any tests necessary to identify any cultured pathogen and necessary antibiotic sensitivity testing - each set of cultures to a maximum of 3 sets **Fee:** $16.80 **Benefit:** 75% = $12.60 85% = $14.30
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:** $20.30 **Benefit:** 75% = $15.25 85% = $17.30
69219	Direct detection of the antigens of Haemophilus influenzae, Streptococcus pneumoniae, Neisseria meningitidis, Group B streptococcus (in CSF and urine specimens only), RSV, cryptococcal antigens and Varicella zoster or detection of Clostridium difficile toxin except where item 69211 has been performed - 1 or more estimations **Fee:** $16.05 **Benefit:** 75% = $12.05 85% = $13.65
69221	Direct detection of Chlamydia from clinical material, not cultures - 1 or more estimations **Fee:** $9.60 **Benefit:** 75% = $7.20 85% = $8.20
69223	Direct detection of herpes simplex virus from clinical material, not cultures - 1 or more estimations **Fee:** $9.60 **Benefit:** 75% = $7.20 85% = $8.20

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:** $13.75 **Benefit:** 75% = $10.35 85% = $11.70
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:** $21.05 **Benefit:** 75% = $15.80 85% = $17.90
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:** $28.35 **Benefit:** 75% = $21.30 85% = $24.10
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:** $35.65 **Benefit:** 75% = $26.75 85% = $30.35
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:** $42.95 **Benefit:** 75% = $32.25 85% = $36.55
69239	6 or more estimations specified in item 69229 **Fee:** $50.15 **Benefit:** 75% = $37.65 85% = $42.65
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:** $7.30 **Benefit:** 75% = $5.50 85% = $6.25
69243	Hepatitis B surface antigen test **Fee:** $13.60 **Benefit:** 75% = $10.20 85% = $11.60
69245	Hepatitis B serology to define the immune status of an individual, including at least hepatitis B surface antibody or hepatitis B core antibody tests, including services specified in items 69243, 69247 and 69249 **Fee:** $18.35 **Benefit:** 75% = $13.80 85% = $15.60
69247	All serological tests performed for the identification of the agent causing acute hepatitis, which must include hepatitis B surface antigen, hepatitis B core antibody and hepatitis A IgM antibody tests and those services specified in items 69243, 69245 and 69249 **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
69249	All tests performed in the follow up of a patient with proven hepatitis B, including hepatitis B surface antigen and either hepatitis B antigen or hepatitis B surface antibody tests, including services specified in items 69243 and 69245 **Fee:** $26.35 **Benefit:** 75% = $19.80 85% = $22.40
69251	Antibiotics or antimicrobial chemotherapeutic agents, concentration in serum, urine or other body fluid, by direct quantitative measurement of the agent - 1 or more estimations **Fee:** $24.05 **Benefit:** 75% = $18.05 85% = $20.45
69253	All microbiological serology during a pregnancy, which must include the determination of 1 of the following - rubella immune status, specific syphilis serology or hepatitis B surface antigen - including any service specified in 1 or more of items 69229, 69243 or 69245, except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy **Fee:** $13.75 **Benefit:** 75% = $10.35 85% = $11.70

69255	All microbiological serology during a pregnancy, which must include the determination of 2 of the following - rubella immune status, specific syphilis serology or hepatitis B surface antigen and including any service specified in 1 or more of items 69229, 69243 or 69245, except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy **Fee:** $21.00 **Benefit:** 75% = $15.75 85% = $17.85
69257	All microbiological serology during a pregnancy, which must include the determination of all 3 of the following - rubella immune status, specific syphilis serology and hepatitis B surface antigen - including any service specified in 1 or more of items 69229, 69243 or 69245, except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy **Fee:** $27.90 **Benefit:** 75% = $20.95 85% = $23.75
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:** $17.80 **Benefit:** 75% = $13.35 85% = $15.15
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:** $27.80 **Benefit:** 75% = $20.85 85% = $23.65
69265	Determination of antibodies to hepatitis C **Fee:** $13.75 **Benefit:** 75% = $10.35 85% = $11.70

GROUP P4 - IMMUNOLOGY

71061	Examination for, and characterisation of, a paraprotein or cryoglobulin not previously characterised on serum, urine or other body fluid by immunoelectrophoresis or immunofixation - 1 or more procedures **Fee:** $28.45 **Benefit:** 75% = $21.35 85% = $24.20
71063	Examination for, and characterisation of, a paraprotein not previously characterised, by immunoelectrophoresis or immunofixation on serum and urine collected concurrently - 2 or more procedures **Fee:** $42.90 **Benefit:** 75% = $32.20 85% = $36.50
71065	Examination of CSF and serum concurrently for the presence of oligoclonal proteins - 2 or more procedures **Fee:** $42.90 **Benefit:** 75% = $32.20 85% = $36.50
71067	Immunoglobulins A, G, M or D, quantitative estimation by any method in serum, urine or other body fluid - 1 estimation **Fee:** $14.65 **Benefit:** 75% = $11.00 85% = $12.50
71069	2 estimations specified in item 71067 **Fee:** $23.15 **Benefit:** 75% = $17.40 85% = $19.70
71071	3 or more estimations specified in item 71067 **Fee:** $31.65 **Benefit:** 75% = $23.75 85% = $26.95
71073	Immunoglobulin G subclasses, quantitative estimation of all 4 subclasses with a maximum of 2 patient episodes in any 12 month period - each patient episode **Fee:** $103.45 **Benefit:** 75% = $77.60 85% = $87.95
71075	Immunoglobulin E (total), quantitative estimation with a maximum of 2 patient episodes in any 12 month period - each patient episode **Fee:** $26.35 **Benefit:** 75% = $19.80 85% = $22.40
71077	Immunoglobulin E (total), quantitative estimation in the follow up of a patient with proven immunoglobulin E secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, with a maximum of 6 patient episodes in any 12 month period - each patient episode **Fee:** $26.35 **Benefit:** 75% = $19.80 85% = $22.40
71079	Estimation of specific immunoglobulin G or E antibodies to single or multiple potential allergens, with a maximum of 4 patient episodes in any 12 month period - each patient episode **Fee:** $23.80 **Benefit:** 75% = $17.85 85% = $20.25
71081	Total haemolytic complement, quantitative estimation **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
71083	Complement components C3, C4 or properdin factor B, quantitative estimation - 1 estimation **Fee:** $19.60 **Benefit:** 75% = $14.70 85% = $16.70
71085	2 estimations specified in item 71083 **Fee:** $28.20 **Benefit:** 75% = $21.15 85% = $24.00
71087	3 or more estimations specified in item 71083 **Fee:** $36.80 **Benefit:** 75% = $27.60 85% = $31.30
71089	Complement components or breakdown products of complement proteins not elsewhere specified in an item in this Schedule, quantitative estimation - 1 estimation **Fee:** $28.40 **Benefit:** 75% = $21.30 85% = $24.15
71091	2 estimations specified in item 71089 **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
71093	3 or more estimations specified in item 71089 **Fee:** $74.50 **Benefit:** 75% = $55.90 85% = $63.35
71097	Antinuclear antibodies, detection in serum or other body fluids, including quantitation if required **Fee:** $24.80 **Benefit:** 75% = $18.60 85% = $21.10

71099	Double-stranded DNA antibodies, quantitative estimation by 1 or more methods other than the Crithidia method **Fee:** $25.85 **Benefit:** 75% = $19.40 85% = $22.00
71101	Antibodies to 1 or more extractable nuclear antigens, detection in serum or other body fluids **Fee:** $16.95 **Benefit:** 75% = $12.75 85% = $14.45
71103	Antibodies to 1 or more extractable nuclear antigens, characterisation after a positive result is obtained by a service specified in item 71101, including that service **Fee:** $50.70 **Benefit:** 75% = $38.05 85% = $43.10
71105	Rheumatoid factor, detection by any technique **Fee:** $8.50 **Benefit:** 75% = $6.40 85% = $7.25
71107	Quantitation of rheumatoid factor if detected, during a service specified in item 71105, including that service **Fee:** $19.65 **Benefit:** 75% = $14.75 85% = $16.75
71109	Antibodies to tissue antigens (acetylcholine receptor, adrenal cortex, cardiolipin, glomerular basement membrane, heart, histone, insulin, insulin receptor, intrinsic factor, islet cell, lymphocyte, neuron, neutrophil cytoplasm, ovary, parathyroid, platelet, salivary gland, skeletal muscle, skin basement membrane and intercellular substance, thyroglobulin, thyroid microsome, thyroid stimulating hormone receptor), qualitative or quantitative - estimation of 1 antibody **Fee:** $33.65 **Benefit:** 75% = $25.25 85% = $28.65
71113	Estimation of 2 antibodies specified in item 71109 **Fee:** $50.55 **Benefit:** 75% = $37.95 85% = $43.00
71115	Estimation of 3 antibodies specified in item 71109 **Fee:** $63.00 **Benefit:** 75% = $47.25 85% = $53.55
71117	Estimation of 4 antibodies specified in item 71109 **Fee:** $71.35 **Benefit:** 75% = $53.55 85% = $60.65
71119	Antibodies to tissue antigens not elsewhere specified in an item in this Schedule, qualitative or quantitative - estimation of 1 antibody **Fee:** $16.90 **Benefit:** 75% = $12.70 85% = $14.40
71121	Estimation of 2 antibodies specified in item 71119 **Fee:** $20.25 **Benefit:** 75% = $15.20 85% = $17.25
71123	Estimation of 3 antibodies specified in item 71119 **Fee:** $23.60 **Benefit:** 75% = $17.70 85% = $20.10
71125	Estimation of 4 or more antibodies specified in item 71119 **Fee:** $26.95 **Benefit:** 75% = $20.25 85% = $22.95
71127	Functional tests for lymphocytes - estimation of proliferation induced by 1 or more mitogens, estimation of proliferation induced by 1 or more antigens or estimation of 1 or more mixed lymphocyte reactions, other than quantitation by microscopy - including a test specified in item 65005, with a maximum of 2 patient episodes in any 12 month period - each patient episode **Fee:** $171.85 **Benefit:** 75% = $128.90 85% = $146.10
71129	2 estimations specified in item 71127 **Fee:** $212.30 **Benefit:** 75% = $159.25 85% = $184.60
71131	3 or more estimations specified in item 71127 **Fee:** $252.70 **Benefit:** 75% = $189.55 85% = $225.00
71135	Determination of neutrophil function - comprising at least 2 of neutrophil chemotaxis, neutrophil phagocytosis, neutrophil oxidative metabolism, neutrophil bactericidal activity - including any test specified in item 65005 (other than nitroblue tetrazolium reduction slide test), with a maximum of 2 patient episodes in any 12 month period - each patient episode **Fee:** $202.70 **Benefit:** 75% = $152.05 85% = $175.00
71137	Determination of cell mediated immunity by multiple antigen delayed type hypersensitivity intradermal skin testing using a minimum of 7 antigens, with a maximum of 2 patient episodes in any 12 month period - each patient episode **Fee:** $29.50 **Benefit:** 75% = $22.15 85% = $25.10

71139	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more specimens of blood, CSF or serous fluid **Fee:** $101.35 **Benefit:** 75% = $76.05 85% = $86.15
71141	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations on 1 or more disaggregated tissue specimens **Fee:** $222.35 **Benefit:** 75% = $166.80 85% = $194.65
71143	Characterisation (not monitoring) of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations in an immunological or haematological malignancy, including any service specified in 1 or more of items 71139 or 71141, on a specimen of blood, CSF, serous fluid or disaggregated tissue **Fee:** $253.40 **Benefit:** 75% = $190.05 85% = $225.70
71145	Characterisation (not monitoring) of 6 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations in an immunological or haematological malignancy, including any service specified in 1 or more of items 71139, 71141 or 71143, on 2 or more specimens of disaggregated tissues or 1 specimen of disaggregated tissue and 1 or more specimens of blood, CSF, serous fluid **Fee:** $413.70 **Benefit:** 75% = $310.30 85% = $386.00
71147	HLA-B27 typing **Fee:** $33.60 **Benefit:** 75% = $25.20 85% = $28.60
71149	Complete tissue typing for 4 HLA-A and HLA-B Class I antigens (including any separation of leucocytes), including any service specified in item 71147 **Fee:** $105.50 **Benefit:** 75% = $79.15 85% = $89.70
71151	Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens **Fee:** $115.85 **Benefit:** 75% = $86.90 85% = $98.50

GROUP P5 - HISTOPATHOLOGY

72801	Histopathology examination of biopsy material including all tissue processing, staining and professional opinion or opinions **Fee:** $78.05 **Benefit:** 75% = $58.55 85% = $66.35
72803	Immediate frozen section diagnosis of biopsy material, including any other histopathology examination **Fee:** $126.80 **Benefit:** 75% = $95.10 85% = $107.80
72805	Immunohistochemical investigation of biopsy material by 1 or more of immunofluorescent, immunoperoxidase or other labelled antibody techniques including any other histopathology examination **Fee:** $96.25 **Benefit:** 75% = $72.20 85% = $81.85
72807	Electron microscopy of biopsy material including any other histopathology examination **Fee:** $102.35 **Benefit:** 75% = $76.80 85% = $87.00

GROUP P6 - CYTOPATHOLOGY

73043	Cytological examination including serial examinations of smears from skin, nipple discharge, lip, mouth, nose or anus for detection of precancerous or cancerous changes - 1 or more examinations **Fee:** $14.80 **Benefit:** 75% = $11.10 85% = $12.60
73045	Cytological examination, other than an examination mentioned in item 73053, for malignancy, including serial examinations and histological services performed on the resulting specimens from washings or brushings from sites not specified in item 73043, or performed on a single specimen of sputum or urine or on 1 or more specimens of other body fluids - 1 or more examinations **Fee:** $29.00 **Benefit:** 75% = $21.75 85% = $24.65
73047	Cytological examination including examination of a series of 3 sputum or urine specimens for malignant cells **Fee:** $60.35 **Benefit:** 75% = $45.30 85% = $51.30
73049	Cytological examination of material obtained from a patient by fine needle aspiration of solid tissue or tissues **Fee:** $36.30 **Benefit:** 75% = $27.25 85% = $30.90
73051	Cytological examination of material obtained from a patient by fine needle aspiration of solid tissue or tissues where the aspiration is performed by a recognised pathologist; or where a recognised pathologist attends the aspiration and performs cytological examination during the attendance **Fee:** $68.00 **Benefit:** 75% = $51.00 85% = $57.80
73053	Routine cytological examination of smears from cervix for detection of pre-cancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia and smears repeated due to an unsatisfactory routine smear - each examination *(See para PP. of explanatory notes to this Category)* **Fee:** $12.40 **Benefit:** 75% = $9.30 85% = $10.55
73055	Cytological examination of smears from cervix in association with the management of previously detected abnormalities including precancerous or cancerous conditions, or the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia, not associated with item 73053 - each examination *(See para PP. of explanatory notes to this Category)* **Fee:** $12.40 **Benefit:** 75% = $9.30 85% = $10.55
73057	Cytological examination of smears from vagina, not associated with items 73053 or 73055 - each examination *(See para PP. of explanatory notes to this Category)* **Fee:** $12.40 **Benefit:** 75% = $9.30 85% = $10.55

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 except blood - 1 or more estimations **Fee:** $323.50 **Benefit:** 75% = $242.65 85% = $295.80
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:** $293.15 **Benefit:** 75% = $219.90 85% = $265.45

GROUP P8 - INFERTILITY AND PREGNANCY TESTS

73521	Semen examination for presence of spermatozoa or examination of cervical mucus for spermatozoa (Huhner's test) **Fee:** $6.70 **Benefit:** 75% = $5.05 85% = $5.70
73523	Semen examination (excluding post vasectomy semen examination), involving measurement of volume, sperm count, motility, examination of stained preparations, morphology, and, if performed, differential count and 1 or more chemical tests, with a maximum of 4 examinations in any 12 month period **Fee:** $27.90 **Benefit:** 75% = $20.95 85% = $23.75
73525	Sperm antibodies, sperm penetrating ability - 1 or more tests **Fee:** $17.95 **Benefit:** 75% = $13.50 85% = $15.30
73527	Chorionic gonadotrophin (beta-HCG), qualitative estimation in serum or urine by 1 or more methods, including serial dilution if performed, for diagnosis of pregnancy - 1 or more estimations **Fee:** $9.80 **Benefit:** 75% = $7.35 85% = $8.35
73529	Chorionic gonadotrophin (beta-HCG), qualitative (if performed) and quantitative estimation in serum by 1 or more methods for diagnosis of hydatidiform mole, HCG - secreting neoplasm, threatened abortion or follow-up of abortion **Fee:** $27.90 **Benefit:** 75% = $20.95 85% = $23.75

GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS

73801	Seminal examination for presence of spermatozoa **Fee:** $6.40 **Benefit:** 75% = $4.80 85% = $5.45
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:** $4.25 **Benefit:** 75% = $3.20 85% = $3.65
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:** $7.65 **Benefit:** 75% = $5.75 85% = $6.55
73805	Urine - microscopical examination of, or catalase test for, bacteria and cells, whether stained or not **Fee:** $4.25 **Benefit:** 75% = $3.20 85% = $3.65
73806	Pregnancy test by 1 or more immunochemical methods **Fee:** $10.45 **Benefit:** 75% = $7.85 85% = $8.90
73807	Microscopical examination of wet film other than urine, including any relevant stain **Fee:** $6.40 **Benefit:** 75% = $4.80 85% = $5.45
73808	Microscopical examination of Gram stained film, including any examination specified in items 73805 and 73807 **Fee:** $8.05 **Benefit:** 75% = $6.05 85% = $6.85
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method **Fee:** $2.15 **Benefit:** 75% = $1.65 85% = $1.85
73810	Microscopical examination screening for fungi in skin, hair or nails - 1 or more sites **Fee:** $6.40 **Benefit:** 75% = $4.80 85% = $5.45
73811	Mantoux test **Fee:** $10.45 **Benefit:** 75% = $7.85 85% = $8.90

INDEX TO PATHOLOGY SERVICES

Service		Item
Abnormal haemoglobins	AH	65027
Acetoacetate	ACAT	66367
Acetylcholine receptor - tissue antigens - antibodies	ARA	71109
Actinomycetes - microbial antibody testing	ACT	69229
Adenovirus - microbial antibody testing	ADE	69229
Adrenal cortex - tissue antigens - antibodies	ADR	71109
Adrenocorticotrophic hormone (ACTH)	ACTH	66391
AFB microscopy & culture of sputum	AFB	69213
Alanine aminotransferase	ALT	66201
Albumin	ALB	66201
Alcohol (ethanol)	ETOH	66367
Aldosterone	ALDS	66391
Alkaline phosphatase	ALP	66201
Alkaline phosphatase- isoenzymes	ALPI	66245
Alpha-fetoprotein	AFP	66353
Alkaline phosphatase - for Down syndrome/neural tube defect testing	NTDD	66321
Alpha-1-antitrypsin	AAT	66255
Alpha-1-acid glycoprotein	AAG	66255
Alpha-2-macroglobulin	AMG	66255
Aluminium	AL	66277
Aluminium - renal dialysis	ALR	66325
Amino acid	AA	66367
Amiodarone	AMIO	66235
Amitriptyline	AMIT	66235
Ammonia	NH3	66367
Amniotic fluid examination	AFE	66243
Amylase	AMS	66201
Amylobarb	AMYL	66235
Androstenedione	ANDR	66377
Angiotensin converting enzyme	ACE	66367
Antibiotic & antimicrobial chemotherapeutic agents, quantitative assay	QAA	69251
Antibodies to - extractable nuclear antigens - detection	ENA	71101
Antibodies to - extractable nuclear antigens - characterisation of antibodies if positive ENA	ENAP	71103
Antibodies to - nuclear antigens - quantitation & measurement of DNA binding if positive ANA	ANAP	71099
Antibodies to - tissue antigens - acetylcholine receptor	ARA	71109
Antibodies to - tissue antigens - adrenal cortex	ADR	71109
Antibodies to - tissue antigens - cardiolipin	ACL	71109
Antibodies to - tissue antigens - centromere	ACA	71119
Antibodies to - tissue antigens - gastric parietal cell	PCA	71119
Antibodies to - tissue antigens - gliadin IgA	GLIA	71119
Antibodies to - tissue antigens - glomerular basement membrane	GBA	71109
Antibodies to - tissue antigens - heart	AHE	71109
Antibodies to - tissue antigens - histone	AHI	71109
Antibodies to - tissue antigens - insulin receptor antibodies	INSA	71109
Antibodies to - tissue antigens - intercellular cement substance of skin	ICCS	71109
Antibodies to - tissue antigens - intrinsic factor	AIF	71109
Antibodies to - tissue antigens - islet cell	AIC	71109
Antibodies to - tissue antigens - Jo-1	JO1	71119
Antibodies to - tissue antigens - keratin	KERA	71119
Antibodies to - tissue antigens - liver/kidney microsomes	LKA	71119
Antibodies to - tissue antigens - lymphocyte	ALY	71109
Antibodies to - tissue antigens - mitochondria	MA	71119
Antibodies to - tissue antigens - neuron	ANE	71109
Antibodies to - tissue antigens - neutrophil cytoplasm	ANCA	71109
Antibodies to - tissue antigens - ovary	AOV	71109
Antibodies to - tissue antigens - parathyroid	PTHA	71109
Antibodies to - tissue antigens - platelet	APA	71109
Antibodies to - tissue antigens - PM-Scl	PM1	71119
Antibodies to - tissue antigens - reticulin	RCA	71119
Antibodies to - tissue antigens - Scl-70	SCL	71119

Service		Item
Antibodies to - tissue antigens - skeletal muscle	SLA	71109
Antibodies to - tissue antigens - skin basement membrane	SKA	71109
Antibodies to - tissue antigens - smooth muscle	SMA	71119
Antibodies to - tissue antigens - thyroglobulin	ATG	71109
Antibodies to - tissue antigens - thyroid microsome	TMA	71109
Antibodies to - tissue antigens - TSH receptor antibody test	TSHA	71109
Antithrombin III	ATH	65037
Anus - cytology on specimens from	SMCY	73043
Apolipoprotein B/A1 ratio	APO	66317
Arginine infusion	ARIN	66297
Arsenic	AS	66277
Aspartate aminotransferase	AST	66201
Aspergillus - microbial antibody testing	ASP	69229
Avian precipitins (bird fancier's disease) - microbial antibody testing	APP	69229
B12 vitamin	RCF	66267
Barbiturate	BARB	66235
Beryllium	BE	66277
Beta-hydroxybutyrate	BHYB	66367
Beta-2-microglobulin	BMIC	66361
Bicarbonate	HCO3	66201
Bilirubin (all fractions)	BILI	66201
Bilirubin (all fractions) - in urine	UBIL	66213
Bilirubin (all fractions) - neonatal	BILN	66365
Bird fancier's disease (Avian precipitins) - microbial antibody testing	APP	69229
Blastomyces - microbial antibody testing	BLM	69229
Bleeding time	BT	65029
Blood - compatability testing	XMAT	65023
Blood - culture	BC	69215
Blood - film	BF	65005
Blood - full examination	FBE	65001
Blood - gases	GAS	66225
Blood - group & blood group antibodies	BGAB	65021
Blood - group antibodies	BGA	65025
Blood - group systems	BGS	65019
Blood - grouping-ABO & RH (D antigen)	BG	65017
Blood - viscosity	VISC	65001
Body cavities - aspirations of - microscopy & culture of material from	MCS3	69209
Body fluids - cytology	BFCY	73045
Bone marrow examination - aspirate	BMEA	65015
Bone marrow examination - trephine	BMET	65013
Bordetella pertussis - microbial antibody testing	BOR	69229
Borrelia burgdorferi - microbial antibody testing	BOB	69229
Breath hydrogen test	BHT	66283
Bromide	BRMD	66235
Brucella - microbial antibody testing	BRU	69229
C-1 esterase inhibitor - quantitative	CEIQ	66257
C-1 esterase inhibitor - functional	CEIF	66258
C-Peptide	CPEP	66391
C-reactive protein	CRP	65001
CA-15.3 antigen	CA15	66261
CA-19.9 antigen	CA19	66261
CA-125 antigen	C125	66261
Cadmium	CD	66277
Caeruloplasmin	CPLS	66361
Calcitonin	CALT	66391
Calcium (total, dialysed or ionized)	CA	66201
Calculus analysis	CALC	66229
Campylobacter jejuni - microbial antibody testing	CAM	69229
Candida - microbial antibody testing	CAN	69229
Carbamazepine (Tegretol)	CARB	66235

Service		Item
Carboxyhaemaglobin	COHB	65027
Carcinoembryonic antigen	CEA	66261
Cardiac enzymes (see group tests)	CE	66205
Cardiolipin - tissue antigens - antibodies	ACL	71109
Catecholamines	CAT	66281
Centromere - tissue antigens - antibodies	ACA	71119
Cervix - cytology - routine	CCR	73053
Cervix - cytology - abnormalities	CCRA	73055
Cervix - microscopy & culture of material from	MCS2	69207
Characterisation of antibodies if positive ENA	ENAP	71103
Chlamydia - direct detection from clinical material	CHLY	69221
Chlamydia - investigation by cultural methods	CHLC	69261
Chlamydia - investigation by DNA probe	CHLP	69261
Chlamydia - microbial antibody testing	CHL	69229
Chlamydia - microbial antigen testing	CHLY	69221
Chloral hydrate	CHHY	66235
Chlorazepate	CHZP	66235
Chloride	CL	66201
Chloroquine	CLOQ	66235
Chlorpromazine	CHLO	66235
Cholesterol	CHOL	66331-41
Cholesterol - HDL	HDLC	66317
Cholinesterase	CHSE	66367
Chorionic gonadotrophin - for pregnancy diagnosis	HCG	73527
Chorionic gonadotrophin - for diagnosis of specified conditions	HCGD	73529
Chorionic gonadotrophin - for Down syndrome/neural tube defect testing	NTDD	66321
Chromium	CR	66277
Chromosome identification and banding		73287-89
Chromosome identification - studies - blood	CSB	73289
Chromosome identification - studies - other than blood	CS	73287
Cimetidine	CMTD	66235
Clobazam	CLOB	66235
Clomipramine	CLOM	66235
Clonazepam (Rivotril)	CLON	66235
Clostridium difficile - microbial antigen testing	CLDT	69219
Coagulation - studies (see group tests)	COAG	65035
Coagulation - time	CT	65029
Coccidioides - microbial antibody testing	CCC	69229
Cold agglutinins	CAG	65005, 65027
Collection of specimen(s) for cytological examination		73051
Compatability testing	XMAT	65023
Complement, total haemolytic	COM	71081
Complement, total haemolytic - components C3	C3	71083
Complement, total haemolytic - components C4	C4	71083
Complement, total haemolytic - properdin factor	BPFB	71083
Complement, total haemolytic - other components	COMP	71089
Copper	CU	66277
Cortisol	CORT	66391
Coxsackie B1-6 - microbial antibody testing	COX	69229
Creatine kinase	CK	66201
Creatine kinase - isoenzymes	CKI	66201
Creatine kinase - isoenzymes (electrophoresis)	CKIE	66245
Creatinine	C	66201
Cryofibrinogen - qualitative	CFID	66213
Cryofibrinogen - quantitative	CFIE	66215
Cryoglobulins - qualitative	CGLD	66213
Cryoglobulins - quantitative	CGLE	66215
Cryoglobulins - investigation by immunoelectrophoresis or immunofixation	RYO	71061
Cryptococcal antigen - microbial antigen testing	CRYN	69219
Cryptococus - microbial antibody testing	CRY	69229

Service		Item
CSF - microscopy & culture of material from	MCS3	69209
CSF antigens - group B streptococcus	STB	69219
CSF antigens - Haemophilus influenzae	HI	69219
CSF antigens - Neisseria meningitidis	NMG	69219
CSF antigens - Streptoccus pneumoniae	SPN	69219
Cultural examination of faeces	FCS	69211
Cylic AMP	CAMP	66391
Cyclosporin A	CLSA	66235
Cystine - qualitative	UCYS	66213
Cystine - quantitative	CYST	66367
Cytology - from body fluids, sputum (1 specimen), urine, washings or brushings	BFCY	73045
Cytology - from cervix- routine	CCR	73053
Cytology - from cervix - abnormalities	CCRA	73055
Cytology - from fine needle aspiration of solid tissues	FNCY	73049
Cytology - from fine needle aspiration of solid tissues - asp. or attendance by a pathologist	FNCP	73051
Cytology - from skin, nipple discharge, lip, mouth, nose or anus	SMCY	73043
Cytology - from vagina	CVO	73057
Cytology - from 3 sputum or urine specimens	SPCY	73047
Cytomegalovirus - microbial antibody testing	CMV	69229
Cytomegalovirus serology in pregnancy - microbial antibody testing	CMVP	69253-57
D-dimer test	DD	65029
D vitamin	VITD	66271
Dehydroepiandrosterone sulphate (DHEAS)	DHEA	66377
Dengue - microbial antibody testing	DEN	69229
Deoxycortisol	DCOR	66391
Desipramine	DESI	66235
Dexamethasone	DXST	66295
Dexamethasone - suppression test	DEXA	66295
DHEAS (Dehydroepiandrosterone sulphate)	DHEA	66377
Diazepam	DIAZ	66235
Differential cell count	DIFF	65005
Digoxin	DIG	66235
Dihydrotesterone	DHTS	66377
Diphenylhydantoin (Dilantin)	DIL	66235
Diphtheria - microbial antibody testing	DIP	69229
Direct Coombs test	CMBS	65005, 65027
Disopyramide (Rythmodan)	DISO	66235
DNA, double-stranded antibodies	DNAD	71099
DNA binding - quantitation & measurement if positive ANA	ANAP	71099
Down syndrome/neural tube defects	NTDD	66321
Doxepin hydrochloride	DOXE	66235
Drugs - abuse treatment programme - assay	DATP	66343
Drugs - inappropriate dosage - assay	DRGO	66231
Drugs - therapeutic - assay (See individual drugs)		66235-39
Dynamic function tests	GHSE	66295-99
Dynamic function tests	GHSG	66295-99
Ear- microscopy & culture of material from	MCS1	69205
Echinococcus - microbial antibody testing	ECC	69299
Echo-coxsackie group - microbial antibody testing	ECH	69229
Electrolytes (see group tests)	E	66207
Electron microscopy of biopsy material	EM	72087
Electrophoresis, to demonstrate - creatine kinase isoenzymes	CKIE	66245
Electrophoresis, to demonstrate - lactate dehydrogenase isoenzymes	LDI	66245
Electrophoresis, to demonstrate - protein classes, or paraprotein	EPP1	66245
Electrophoresis, to demonstrate - protein classes or presence & amount of paraprotein classes, concurrent collection	EPP2	66247
Entamoeba histolytica - microbial antibody testing	AMO	69229
Enzyme assays of solid tissue or tissues	ENZS	66285
Epstein Barr virus - microbial antibody testing	EBV	69229
Erythrocyte - assessment of haemolysis	ERYH	65009
Erythrocyte - assessment of metabolic enzymes	ERYM	65009

Service		Item
Erythrocyte - count	RCC	65001
Erythrocyte - sedimentation rate	ESR	65001
Ethosuximide (Zarontin)	THO	66235
Euglobulin clot lysis time	ECLT	65037
Extractable nuclear antigens - detection of antibodies to	ENA	71101
Eye - microscopy & culture of material from	MCS1	69205
Factor II	FII	65045
Factor V	FV	65045
Factor VII	FVII	65045
Factor VIII	VIII	65045
Factor IX	FIX	65045
Factor X	FX	65045
Factor XI	FXI	65045
Factor XII	FXII	65045
Factor XIII	XIII	65045
Factor XIII deficiency test	F13D	65029
Faecal fat	FFAT	66283
Faecal fat - haemoglobin (chemical test)	FHC	66217
Faecal fat - haemoglobin (immunological test	FHI	66219
Faecal fat - porphyrins (qualitative test)	FPR	66217
Faecal fat - reducing substances	FRS	66217
Faeces - cultural examination	FCS	69211
Faeces - microscopic examination for parasites	OCP	69203
Ferritin (see also Iron studies)	FERR	66355
Fibrin monomer	FM	65029
Fibrinogen	FIB	65029
Fibrinogen - degradation products	FDP	65029
Fitzgerald factor	FGF	65045
Flecainide	FLEC	66235
Fletcher factor	FF	65045
Fluorescent treponemal antibody - absorption test (FTA-ABS) - microbial antibody testing	FTA	69229
Fluoxetine	FLUX	66235
Folate	RCF	66267
Follicle stimulating hormone (FSH)	FSH	66377
Frozen section diagnosis of biopsy material	FS	72803
Fructosamine	FRUC	66201
Full blood examination	FBE	65007
Gamma glutamyl transpeptidase	GGT	66201
Gastric parietal cell - tissue antigens - antibodies	PCA	71119
Gastrin	GAST	66391
Gliadin IgA - tissue antigens - antibodies	GLIA	71119
Globulin	GLOB	66201
Glomerular basement membrane - tissue antigens - antibodies	GBA	71109
Glucagon	GLGO	66391
Glucagon stimulation test	GSTC	66297
Glucose	GLUC	66201
Glucose - tolerance test	GTT	66201
Glycolated haemoglobin (Hb Alc)	GHB	66319
Gold	AU	66277
Gonadotrophin	GRHS	66297
Group B streptococcus - CSF antigens	STB	69219
Group B streptococcus - microbial antigen testing	STB	69219
Group P9 - simple basic pathology tests		73801-11
Growth hormone	GH	66391
Growth hormone - stimulation by exercise or L-dopa	GHSE	66295
Growth hormone - suppression by dexamethasone or glucose	GHSG	66295
Haematocrit	HCT	65001
Haemoglobin estimation	HB	65001
Haemoglobin estimation - in urine	UHB	66213
Haemoglobinopathy tests	HMGP	65011

Service		Item
Haemophilus influenzae - CSF antigens	HI	69219
Haemophilus influenzae - microbial antibody testing	HUS	69229
Haemophilus influenzae - microbial antigen testing	HI	69219
Heart - tissue antigens - antibodies	AHE	71109
Haloperidol	HALO	66235
Haptoglobins	HGLB	66361
HDL cholesterol	HDLC	66317
Heparin - cofactor II	HRNC	65037
Heparin - estimation	HEPR	65043
Hepatitis delta antibody - anti-delta - microbial antibody testing	HDA	69229
Hepatitis serology - acute hepatitis	HEP	69247
Hepatitis serology - follow-up of proven hepatitis	BHEPB	69249
Hepatitis serology - hepatitis B serology to define immune status	HEP1	69245
Hepatitis serology - hepatitis B surface antigen HBsAg	HBSA	69243
Hepatitis serology - hepatitus C	HEPC	69265
Hepatitis serology - in pregnancy	HEPP	69253-57
Hepatitis serology - hepatitis	HEPC	69229
Hepatitis serology - hepatitis delta antibody	HDA	69229
Herpes simplex virus - direct detection from clinical material	HSV	69223
Herpes simplex virus - investigation by cultural methods	HSVC	69263
Herpes simplex virus - microbial antibody testing	HPA	69229
Herpes simplex virus - microbial antigen testing	HSV	69223
Heterophile antibodies	IM	65005, 65027
HIAA (hydroxyindoleacetic acid)	HIAA	66367
Histamine	HIAM	66367
Histone - tissue antigens - antibodies	AHI	71109
Histopathology of biopsy material	HIST	72801
Histoplasma - microbial antibody testing	HIP	69229
HLA typing - HLA-B27	HLAB	71147
HLA typing - HLA class 1	HLA1	71149
HLA typing - HLA class 2	HLA2	71151
HMMA (hydroxy-3-methoxymandelic acid previously known as VMA)	HMMA	66281
HMPG (hydroxy methoxy phenylethylene glycol)	HMPG	66281
Hormone receptor assay - breast	HRA	66315
Hormone receptor assay - ovary	HRO	66315
Hormones - adrenocorticotrophic hormone	ACTH	66391
Hormones - aldosterone	ALDS	66391
Hormones - androstanedione	ANDR	66377
Hormones - C-Peptide	CPEP	66391
Hormones - calcitonin	CALT	66391
Hormones - cortisol	CORT	66391
Hormones - cyclic AMP	CAMP	66391
Hormones - dehydroepiandrosterone sulphate	DHEA	66377
Hormones - dihydrotestosterone	DHTS	66377
Hormones - follicle stimulating hormone	FSH	66377
Hormones - gastrin	GAST	66391
Hormones- glucagon	GLGO	66391
Hormones- gonadotrophin	GRHS	66297
Hormones - growth hormone	GH	66391
Hormones - stimulation by exercise or L-dopa	GHSE	66295
Hormones - suppression by dexamethasone or glucose	GHSG	66295
Hormones - hormone receptor assay- breast	HRA	66315
Hormones - hormone receptor assay - ovary	HRO	66315
Hormones - human chorionic gonadotrophin - for pregnancy diagnosis	HCG	73527
Hormones - human chorionic gonadotrophin - for diagnosis of specified conditions	HCGD	73529
Hormones - human chorionic gonadotrophin - for Down syndrome/neural tube defect testing	NTDD	66321
Hormones - human placental lactogen	HPL	66373
Hormones - hydroxyprogesterone	OHP	66377
Hormones - insulin	INS	66391
Hormones - insulin, hypoglycaemia test	INHY	66297

Service		Item
Hormones - luteinizing hormone	LH	66377
Hormones - oestradiol	E2	66377
Hormones - oestriol	E3	66373
Hormones - oestrone	E1	66377
Hormones - parathyroid hormone	PTH	66391
Hormones - pentagastrin	PSTR	66297
Hormones - progesterone	PROG	66377
Hormones - prolactin	PROL	66377
Hormones - renin	REN	66391
Hormones - sex hormone binding globulin	SHBG	66377
Hormones - somatomedin	SOMA	66391
Hormones - testosterone	TES	66377
Hormones - thyroid stimulating hormone (where not requested as part of TFTs)	TSH	66371, 66377
Hormones - urine steroid fraction or fractions	USF	66391
Hormones - vasoactive intestinal peptide	VIP	66391
Hormones - vasopressin	ADH	66391
Hormones - 11 deoxycortisol	DCOR	66391
Hormones & hormone binding proteins (See individual hormones and proteins)		66377, 66391
Huhner's test	HT	73521
Human chorionic gonadotrophin - for pregnancy diagnosis	HCG	73527
Human chorionic gonadotrophin - for diagnosis of specified conditions	HCGD	73529
Human chorionic gonadotrophin - for Down syndrome/neural tube defect testing	NTDD	66321
Human placental lactogen	HPL	66373
HVA (homovanillic acid)	HVA	66281
Hydatid - microbial antibody testing	HYD	69229
Hydroxy methoxy phenylethylene glycol	HMPG	66281
Hydroxy-3-methoxymandelic acid previously known as VMA)	HMMA	66281
Hydroxychloroquine	HOCQ	66235
Hydroxyindoleacetic acid	HIAA	66367
Hydroxyprogesterone	OHP	66377
Hydroxyproline	HYDP	66367
Imipramine	IMIP	66235
Immediate frozen section diagnosis of biopsy material	FS	72803
Immunoglobulins - A	IGA	71067
Immunoglobulins - D	IGD	71067
Immunoglobulins - E (total)	IGE	71075-79
Immunoglobulins - G	IGG	71067
Immunoglobulins - G, 4 subclasses	SIGG	71073
Immunoglobulins - M	IGM	71067
Immunohistochemical investigation of biopsy material	HIS	72805
Infectious mononucleosis	IM	69229
Influenza A - microbial antibody testing	FLA	69229
Influenza B - microbial antibody testing	FLB	69229
Insulin	INS	66391
Insulin - hypoglycaemia test	INHY	66297
Insulin - tissue antigens - antibodies	AINS	71109
Insulin receptor antibodies - tissue antigens - antibodies	INSA	71109
Intercellular cement substance of skin - tissue antigens - antibodies	ICCS	71109
Intestinal disaccharidases	INTD	66285
Intrinsic factor - tissue antigens - antibodies	AIF	71109
Iron studies (iron, transferrin & ferritin)	IS	66263
Islet cell - tissue antigens - antibodies	AIC	71109
Jo-1 - tissue antigens - antibodies	JO1	71119
Keratin - tissue antigens - antibodies	KERA	71119
L-dopa	GHLD	66295
Lactate	LACT	66367
Lactate - dehydrogenase	LDH	66201
Lactate - dehydrogenase isoenzymes	LDI	66245
Lamellar body phospholipid	LBPH	66243
Lead	PB	66279

Service		Item
Microbial antigen testing - herpes simplex virus	HSV	69263
Microbial antigen testing - Neisseria gonorrhoeae	GON	69219
Microbial antigen testing - Neisseria meningitidis	NMG	69219
Microbial antigen testing - respiratory syncytial virus	RSVN	69219
Microbial antigen testing - Streptococcus pneumoniae	SPN	66219
Microbial antigen testing - Varicella zoster	VCZN	69219
Micropolyspora faeni - microbial antibody testing	MIC	69229
Microscopic examination of - faeces for parasites	OCP	69203
Microscopic examination of - material other than blood	M	69201
Microscopy & culture of - material from nose, throat, eye or ear	MCS1	69205
Microscopy & culture of - material from skin, superficial sites, urethra, vagina, cervix or rectum	MCS2	69207
Microscopy & culture of - post-op wounds, aspirations of body cavities, synovial fluid, CSF & op/biopsy specimens		MCS369209
Microscopy & culture of - specimens of sputum	MCS2	69207
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria	AFB	69213
Microscopy, culture, identification & sensitivity on urine	UMCS	69217
Mitochondria - tissue antigens - antibodies	MA	71119
Mouth - cytology on specimens from	SMCY	73043
Mucin-like carcinoma associated antigen	MCA1	66261
Mumps - microbial antibody testing	MUM	69229
Murray Valley encephalitis- microbial antibody testing	MVE	69229
Mycobacteria microscopy & culture of sputum	AFB	69213
Mycoplasma pneumoniae - microbial antibody testing	MYC	69229
Myoglobin in urine	UMY	66213
N-acetyl procainamide	NAPC	66235
Neisseria gonorrhoeae - microbial antigen testing	GON	69219
Neisseria menigitidis - CSF antigens	NMG	69219
Neisseria menigitidis - microbial antibody testing	MEN	69229
Neisseria menigitidis - microbial antigen testing	NMG	69219
Neural tube defects/Down syndrome	NTDD	66321
Neuron - tissue antigens - antibodies	ANE	71109
Neuron specific enolase	NSEN	66261
Neutrophil cytoplasm - tissue antigens - antibodies	ANCA	71109
Neutrophil functions	NFT	71135
Newcastle disease - microbial antibody testing	NCD	69229
Nickel	NI	66277
Nipple discharge - cytology on specimens from	SMCY	73043
Nitrazepam	NITR	66235
Nordothiepin	NDIP	66235
Norfluoxetine	NFLE	66235
Nortriptyline	NORT	66235
Nose - cytology on specimens from	SMCY	73043
Nose - microscopy & culture of material	MCS1	69205
Nuclear antigens - detection of antibodies to	ANA	71079
Oestradiol	E2	66377
Oestriol	E3	66373
Oestriol - for Down syndrome /neural tube defect testing	NTDD	66321
Oestrone	E1	66377
Oligoclonal proteins	OGP	71065
Op/biopsy specimens - microscopy & culture of material from	MCS3	69209
Osmolality, serum or urine	OSML	66223
Ovary - tissue antigens - antibodies	AOV	71109
Oxalate	OXAL	66367
Oxazepam	OXAZ	66235
PAA (phenyl acetic acid)	PAA	66281
Palmitic acid in amniotic fluid	PALM	66243
Pap smear	CCR	73053
Papanicolaou test	CCR	73053
Paracetamol	PARA	66235
Parainfluenza 1 - microbial antibody testing	PF1	69229
Parainfluenza 2 - microbial antibody testing	PF2	69229

Service		Item
Parainfluenza 3 - microbial antibody testing	PF3	69229
Paraprotein investigation - by electrophoresis	EPPI	66245
Paraprotein investigation - by immunoelectrophoresis or immunofixation	PPRO	71061
Paraprotein investigation - on concurrently collected serum or urine	PPSU	71063
Paraquat	PARQ	66235
Parasites - microscopic examination of faeces	OCP	69203
Parathyroid hormone (PTH)	PTH	66391
Parathyroid - tissue antigens - antibodies	PTHA	71109
Paratyphi - microbial antibody testing	PTY	69229
Partial thromboplastin time	PTT	65029
Passovy factor	PF	65045
Patient episode initiation fees	PEI	73901-15
Pentobarbitone	PENT	66235
Pentagastrin	PSTR	66297
Perhexiline	PHEX	66235
Pertussis - microbial antibody testing	PER	69229
pH measurement of body fluids other than urine	PH	66213
Phenobarbitone	PHBA	66235
Phensuximide	PHEN	66235
Phenylacetic acid	PAA	66281
Phenytoin	PHEY	66235
Phosphate	PHOS	66201
Phosphatidylglycerol	PTGL	66243
Plasminogen	PLAS	65037
Platelet - aggregation	PLTG	65041
Platelet - count	PLTC	65001
Platelet - tissue antigens - antibodies	APA	71109
PM-Sc1 - tissue antigens - antibodies	PM1	71119
Poliomyelitis - microbial antibody testing	PLO	69229
Porphobilingen in urine	UPG	66213
Porphyrins (quantitative test, 1 or more fractions)	PR	66281
Porphyrins in urine (qualitative test)	UPR	66213
Potassium	K	66201
Prealbumin	PALB	66361
Prednisolone	PRED	66235
Pregnancy serology - 1 estimation	MSP1	69253
Pregnancy serology - 2 estimations	MSP2	69255
Pregnancy serology - 3 estimations	MSP3	69257
Pregnancy testing		73805
Pregnancy testing - diagnosis	HCG	73527
Pregnancy testing - diagnosis of specified conditions	HCGD	73529
Pregnancy testing - diagnosis for Down syndrome/neural tube defect	NTDD	66321
Primidone	PRIM	66235
Procainamide	PCAM	66235
Progesterone	PROG	66377
Prolactin	PROL	66377
Prominal	PROM	66235
Propranolol	PPNO	66235
Prostate specific antigen	PSA	66357
Prostatic acid phosphatase	ACP	66357
Protein - C	PROC	65037
Protein - S	PROS	65037
Protein - quantitative estimation of - alpha fetoprotein	AFP	66353
Protein - quantitative estimation of - for Down syndrome/neural tube defect testing	NTDD	66321
Protein - quantitative estimation of - alpha-1-antitrypsin	AAT	66255
Protein - quantitative estimation of - alpha-2-macroglobulin	AMAC	66255
Protein - quantitative estimation of - beta-2-microglobulin	BMIC	66361
Protein - quantitative estimation of - C-1 esterase inhibitor	CEI	66257
Protein - caeruloplasmin	CPLS	66361
Protein - quantitative estimation of - caeruloplasmin - classes or paraprotein by electrophoresis	EPPI	66245

Service		Item
Protein - quantitative estimation of - caeruloplasmin - classes or presence & amount of paraprotein classes, concurrent collection	EPP2	66247
Protein - quantitative estimation of - ferritin (see also Iron studies)	FERR	66355
Protein - quantitative estimation of - haptoglobins	HGLB	66361
Protein - quantitative estimation of - microalbumin	MALB	66361
Protein - quantitative estimation of - total	PROT	66201
Proteus OX 19 - microbial antibody testing	POX	69229
Proteus OXK - microbial antibody testing	POK	69229
Prothrombin time	PT	65029
Pyruvate	PVTE	66367
Q fever - microbial antibody testing	QFF	69229
Quinalbarb	QUIB	66235
Quinidine	QUIN	66235
Quinine	QNN	66235
Rapid plasma reagin test - microbial antibody testing	RPR	69229
RAST	RAST	71079
Rectum - microscopy & culture of material from	MCS2	69207
Red cell folate & serum B12 & serum folate if required	RCF	66267
Red cell porphyrins - qualitative test	RCP	65027
Referred specimen fee		73921
Renin	REN	66391
Respiratory syncytial virus - microbial antibody testing	RSV	69229
Respiratory syncytial virus - microbial antigen testing	RSVN	69219
Reticulin - tissue antigens - antibodies	RCA	71119
Reticulocyte count	RETC	65001
Rheumatoid factor	RF	71105
Respiratory syncytial virus - factor quantitation	RFQ	71107
Ross River virus - microbial antibody testing	RRV	69229
RSV- respiratory syncytial virus	RSVN	69219
RSV- respiratory syncytial virus - microbial antibody testing	RUB	69229
RSV- respiratory syncytial virus - serology	RUB	69229
Salicylate - aspirin	SALI	66235
Salivary gland - tissue antigens - antibodies	ASG	71109
Salmonella typhi (H) - microbial antibody testing	SAH	69229
Salmonella typhi (O) - microbial antibody testing	SAO	69229
Schistosoma - microbial antibody testing	STO	69229
Scl-70 - tissue antigens - antibodies	SCL	71119
Secretin	SSGR	66297
Selenium	SE	66277
Semen examination	SEE	73523
Semen examination - for spermatozoa (post vasectomy)	SES	73521
Serotonin	5HT	66367
Serum - B12	B12	66265
Serum - folate (with B12)	FOL	66265
Serum - folate (with B12 red cell folate)	RCF	66267
Sex hormone binding globulin	SHBG	66377
Skeletal muscle - tissue antigens - antibodies	SLA	71109
Skin - cytology	SMCY	73043
Skin - microscopy & culture of material from	MCS2	69207
Skin basement membrane - tissue antigens - antibodies	SKA	71109
Snake venom	HISS	6623
Smooth muscle - tissue antigens - antibodies	SMA	71119
Sodium	NA	66201
Solid tissue or tissues - chemical assays	ENZS	66285
Solid tissue or tissues - cytology of fine needle aspiration	FNCY	73049
Solid tissue or tissues - cytology of fine needle aspiration by, or in presence of pathologisy	FNCP	73051
Somatomedin	SOMA	66391
Sotalol	SALL	66235
Specific IgG or IgE antibodies	RAST	71079
Specimen referred fee		73921

Service		Item
Sperm antibodies	SAB	73525
Sperm antibodies - penetrating ability	SPA	73525
Sputum - cytology (1 specimen)	BFCY	73045
Sputum - cytology (3 specimens)	SPCY	73047
Sputum - microscopy & culture of specimens	MCS2	69207
Sputum - for mycobacteria	AFB	69213
Stelazine	STEL	66235
Steroid fraction or fractions in urine	USF	66391
Streptococcal serology - anti-DNASE B titre - microbial antibody testing	ADNB	69229
Streptococcal serology - anti-streptolysin O titre - microbial antibody testing	ASOT	69229
Streptococcus - Group B	STB	69219
Streptococcus pneumoniae - CSF antigens	SPN	69219
Streptococcus pneumoniae - microbial antibody testing	PCC	69229
Streptococcus pneumoniae - microbial antigen testing	SPN	69219
Strontium	SR	66277
Sulthiame (Ospolot)	SUL	66235
Synacthen stimulation test	SYNS	66297
Syphilis serology (see group tests)	STS	69231
Testosterone	TES	66377
Tetanus - microbial antibody testing	TET	69229
Thalassaemia studies	TS	65011
Theophylline	THEO	66235
Thermoactinomyces vulgaris - microbial antibody testing	THE	69229
Thermopolyspora - microbial antibody testing	TPS	69229
Thiopentone	TOPO	66235
Thioridazine	THIO	66235
Throat - microscopy & culture of material from	MCS1	69205
Thrombin time	TT	65029
Thyroglobulin	TGL	66261
Thyroglobulin - tissue antigens - antibodies	ATG	71109
Thyroid - function tests	TFT	66291
Thyroid - stimulating hormone (where not requested as part of TFTs)	TSH	66371, 66377
Thyroid microsome - tissue antigens - antibodies	TMA	71109
Thyrotrophin releasing hormone test	TRH	66293
Total free fatty acids	TFFA	66367
Total protein	PROT	66201
Toxocara - microbial antibody testing	TOC	69229
Toxoplasma - microbial antibody testing	TOX	69229
TPHA(Treponema pallidum haemagglutination test) - microbial antibody testing	TPHA	69229
Treponema pallidum haemagglutination test - microbial antibody testing	TPHA	69229
Trichinosis - microbial antibody testing	TOS	69229
Triglycerides	TRIG	66331-41
Trimipramine	TRIM	66235
TSH receptor antibody test - tissue antigens - antibodies	TSHA	71109
TSH (where not requested as part of a thyroid function test)	TSH	66371, 66377
Tumour markers - CA-15.3 antigen	CA15	66261
Tumour markers - CA-19.9 antigen	CA19	66261
Tumour markers - CA-125 antigen	C125	66261
Tumour markers - carcinoembryonic antigen	CEA	66261
Tumour markers - mammary serum antigen	MSA	66261
Tumour markers - mucin-like carcinoma associated antigen	MCA	66261
Tumour markers - neuron specific enolase	NSEN	66261
Tumour markers - prostate specific antigen	PSA	66357
Tumour markers - prostatic acid phosphatase-1 or more fractions	ACP	66357
Tumour markers - thyroglobulin	TGL	66261
Tryptic activity in faeces	TAF	66323
Typhus, Weil-Felix - microbial antibody testing	TYP	69229
Urate	URAT	66201
Urea	U	66201
Urea, electrolytes, creatinine (see group tests)	U&E	66211

Service		Item
Urethra - microscopy & culture of material from	MCS2	69207
Urine - bilirubin	UBIL	66213
Urine - cytology - on 1 specimen	BFCY	73045
Urine - cytology - on 3 specimens	SPCY	73047
Urine - cystine (cysteine)	UCYS	66213
Urine - haemoglobin	UHB	66213
Urine - melanin (melanogen)	UML	66213
Urine - microscopy, culture, identification & sensitivity	UMCS	69217
Urine - myoglobin	UMY	66213
Urine - porphobilinogen	UPG	66213
Urine - porphyrins (qualitative test)	UPR	66213
Urine - steroid fraction or fractions	USF	66391
Urine - urobilinogen	UUB	66213
Vagina - cytology on specimens from	CVO	73057
Vagina - microscopy & culture of material from	MCS2	69207
Valproate (Epilim)	VALP	66235
Vancomycin	VAN	66235
Varicella zoster - microbial antibody testing	VCZ	69229
Varicella zoster - microbial antigen testing	VCZN	69219
Vasoactive intestinal peptide	VIP	66391
Vasopressin	ADH	66391
VDRL (Venereal Disease Research Laboratory) - microbial antibody testing	VDRL	69229
Viscosity of blood or plasma	VISC	65001
Vitamins - B12	RCF	66267
Vitamins - D	VITD	66271
Vitamins - folate	RCF	66267
Vitamins - quantitative estimation of A, B1, B2, B3, B6, C or E	VIT	66269
Von Willebrands factor	VWF	65045
Von Willebrands factor antigen	VWA	65045
Warfarin	WFR	66235
Xylose	XYL	66367
Yersinia enterocolitica - microbial antibody testing	YER	69229
Zinc	ZN	66367