Supplement to

MEDICARE BENEFITS SCHEDULE BOOK

OF 1 NOVEMBER 1996

EFFECTIVE 1 MAY 1997

COMMONWEALTH DEPARTMENT OF HEALTH AND FAMILY SERVICES

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SUPPLEMENT TO 1 NOVEMBER 1996 MEDICARE BENEFITS SCHEDULE BOOK

AMENDMENTS EFFECTIVE 1 MAY 1997

This supplement provides details of changes to the 1 November 1996 edition of the Medicare Benefits Schedule book. Fee levels for some Diagnostic Imaging services have been amended effective from 19 February 1997 and some Pathology amendments are also included effective 20 March 1997. Any item not included in the summary of changes listed herein remains as it is shown in the 1 November 1996 Schedule book.

At the time of printing, the relevant legislation giving authority for the changes included herein may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny.

REVIEW OF GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- prolonged professional attendances (amendment to item descriptors and re-evaluation of Schedule fees)
- carbon-labelled urea breath testing (amendment to item descriptor)
- autologous stem cell transplantation (amendment to item descriptor to include additional indications)
- laser photocoagulation (amendment to item descriptors to include treatment of cafe-au-lait macules and naevi of Ota)
- assistance in the administration of an anaesthetic (new item to cover anaesthetic assistance in life threatening situations, and deletion of Item 17500)
- administration of an anaesthetic (addition of anaesthetic units to items not previously assigned anaesthetic unit values and an increase in the anaesthetic unit value for cataract surgery)
- regional or field nerve blocks (new nerve block items for the management of post-operative pain in association with knee and shoulder surgery)
- excision of skin lesions (review of structure introduced from 1 November 1996 - **see below**)
- assistance at operation (including the reinstatement of rebates for 26 services, the withdrawal of rebates for 44 services, the inclusion of two new items for assistance at cataract surgery and an increase in the threshold amount which determines services attracting benefits at the 20% rate)
- oral and maxillofacial surgery (new items and amended fees and descriptions)

Review of items covering excision of skin lesions

The key element of the Schedule structure for the treatment of skin lesions introduced from 1 November 1996 was the payment of Medicare benefits according to the type, size and site of the lesion, based on the initial clinical diagnosis of the lesion. However, the effect of this structure had been a 30% increase in Medicare outlays above that anticipated. This necessitated an urgent review of the items.

A revised structure has been developed in co-operation with the profession, represented by the Australian Medical Association, the Australian Society of Plastic Surgeons, the Australasian College of Dermatologists, the Australian Association of Surgeons, the Royal Australian College of General Practitioners and the Rural Doctors Association, with the main features as follows:-

- benefits are payable for non-malignant lesions based on clinical diagnosis, provided the specimen is sent for histological examination
- histological proof of malignancy is required prior to itemisation of accounts for Medicare benefits purposes
- a separate item has been introduced for the excision of residual or recurrent BCCs or SCCs , performed by a specialist or a medical practitioner other than the practitioner who provided the initial treatment, and restricted to lesions on the head and neck
- a higher level of benefit no longer applies for removal of lesions from the hand or foot
- the excision of lesions to establish diagnosis of tumours covered by Items 31300 to 31335 has been included in Items 31205 to 31240

New items have also been included for the excision of large subcutaneous lipomas, and benign and malignant tumours of soft tissue.

REPEAL OF SECTIONS 11 & 12 OF THE HEALTH INSURANCE ACT - INCLUSION OF SERVICES PREVIOUSLY COVERED BY MEDICARE BENEFITS ADVISORY COMMITTEE (MBAC) PRINCIPLES

Sections 11 and 12 provide for the MBAC to recommend to the Health Insurance Commission increased fees for services of "unusual length or complexity". The MBAC also has the power to recommend "principles" on which the Commission could base the payment of future cases of the same nature.

Sections 11 and 12 will be repealed effective from 19 June 1997 in line with the 1996 Budget initiative to fully apply the principle that Medicare fees are regarded as being reasonable, on average, for the 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 involved. All applications to MBAC received by the Commission prior to the repeal date will be considered.

Following a review of services currently covered by MBAC principles, a number of new services have been introduced into the Schedule. The following is a list of services transferred from the "non-specific" list at page 261 of the 1 November MBS book, with new item numbers as indicated:-

30000 (145) - 38270	30000 (174) - 30255	30000 (180) - 32115	30000 (184) - 41868
30000 (188) - 13110	30000 (225) - 47920	30000 (226) - 47982	30000 (230) - 41564
30000 (238) - 35600	30000 (239) - 35600	30000 (246) - 41832	30000 (248) - 38275
30000 (250) - 41672	30000 (260) - 37045	30000 (269) - 37223	30000 (271) - 36811
30000 (276) - 42807	30000 (277) - 42808	30000 (280) - 42667	30000 (281) - 35750
30000 (282) - 35753	30000 (283) - 35756	30000 (287) - 35710	30000 (289) - 45555
30000 (290) - 30393	30000 (292) - 13757	30000 (293) - 32200	30000 (294) - 32203
30000 (295) - 32206	30000 (296) - 32209	30000 (297) - 36604	30000 (298) - 35612
30000 (299) - 35613	30000 (300) - 32212		

In addition, the following new or amended items have been included as a result of the above review:-

13290, 13292, 13319, 16015, 18016, 30419, 35593, 38253, 38259, 38438, 39140, 41869, 42670, 42676

Further consideration will be given to including other services currently covered by MBAC Recommendations/Precedents prior to 19 June.

Prolonged Anaesthesia

The question of Medicare benefits for prolonged anaesthesia following the repeal of Sections 11 and 12 is still under consideration. Details of any new arrangements will be advised to anaesthetists prior to 19 June.

REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

As of 1 November 1996 new Medicare referral arrangements were introduced to cover referrals from specialists and consultant physicians. Attention is drawn to the following notes relating to referrals which appeared in the 1 November 1996 MBS book.

5.6.1 Where a referral originates from a specialist or a consultant physician, the referral is valid for 3 months, except where the referred patient is an in-patient. For in-patients, the referral is valid for 3 months or the duration of the admission whichever is the longer.

5.6.2 As it is expected that the patient's general practitioner will be kept informed of the patient's progress, a referral from a specialist or a consultant physician must include the name of the patient's general practitioner and/or practice. Where a patient is unable or unwilling to nominate a general practitioner or practice this must be stated in the referral.

5.6.3 Where the referral originates from a practitioner other than those listed in 5.6.1, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). The purpose in permitting a referral for longer than 12 months is to obviate the necessity for a chronically ill patient, who 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. Referrals for longer than 12

months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

5.6.4 The referral is valid for the period specified in the referral which is taken to be the date of the specialist's or consultant physician's first service.

SAFETY NET

The Medicare "safety net" increased with effect from 1 January 1997 to $276.80 (see para 1.1 of General Explanatory Notes to the 1 November 1996 Medicare Benefits Schedule book).

MAXIMUM PATIENT GAP

The maximum patient gap between the Medicare Benefits Schedule fee and the benefit payable for out-of-hospital services increased from $30.20 to $50.00 from 17 December 1996. Please refer to the Ready Reckoner at page 451 of the 1 November 1996 Medicare Benefits Schedule for revised benefits details.

SUMMARY OF CHANGES

The 1 May 1997 changes to the MBS are summarised below and are identified in the Schedule pages by one or more of the following symbols appearing above the item number:-

(a)	new item	†
(b)	description amended	‡
(c)	fee amended	+
(d)	anaesthetics amended	@
(e)	item number change	*
(f)	new item (previous Ministerial Determination)	▲
(g)	addition/deletion (Assist.)	A

New Items

319	30393	32209	37223	42807	53016	66432	72847
13110	30419	32212	38270	42808	53458	69280	72851
13290	31200	35600	38275	45555	53459	69283	72852
13292	31295	35612	39140	47920	53460	72813	72855
13319	31345	35613	41564	47982	65052	72816	72856
13757	31350	35710	41672	51315	65053	72817	73910
16015	31355	35750	41832	51318	66322	72823	73912
17503	32115	35753	41868	52034	66427	72824	
18210	32139	35756	41869	52106	66428	72825	
18211	32200	36604	42667	52337	66429	72830	
18212	32203	36811	42670	52633	66430	72836	
30255	32206	37045	42676	52636	66431	72846	

Ceased Items

17500 72801 72803 72805 72807

Amended Descriptions

160	31205	31270	31340	65005	69274
161	31210	31275	35593	66327	69275
162	31215	31280	38253	66405	69277
163	31220	31285	38259	69253	69278
164	31225	31290	38438	69255	69279
12533	31230	31300	38470	69257	73053
13760	31235	31305	51300	69266	73903
14106	31240	31310	51303	69267	73905
14109	31245	31315	51800	69268	
14112	31250	31320	51803	69269	
14115	31255	31325	52122	69270	
14118	31260	31330	60500	69271	
18016	31265	31335	60503	69272	

Amended Anaesthetics

13112	30196	30213	31002	42581
13818	30197	30406	32500	42702
13845	30205	31000	39003	52018
14203	30207	31001	39006	

Amended Fees

160	163	53215	65013	66299	73049
161	164	53218	66295	73045	73051
162	52122	53224	66297	73047	

Item Number Change

Old	New	Old	New	Old	New
30116	31205	30119	31210	30120	31215
30123	31220	30124	31225	30127	31230
30128	31235	30130	31240	30131	31245
30133	31250	30134	31255	30137	31260
30138	31265	30141	31270	30142	31275
30145	31280	30146	31285	30148	31290
30149	31300	30151	31305	30152	31310
30154	31315	30155	31320	30157	31325
30158	31330	30160	31335	30161	31340

(Assist.) added to Item

30023	30614	32045	32508	37375	45656	48609
30067	30634	32046	32511	37438	46500	49366
30068	30635	32047	32514	37616	46501	50336
30110	30638	32051	32517	37821	46502	50339
30111	30641	32054	35536	37824	47333	
30168	30644	32057	35636	37827	47345	
30341	32033	32060	36549	39128	47357	
30342	32036	32063	36645	40009	47375	
30609	32039	32066	36648	45623	47930	
30612	32042	32096	37372	45644	47936	

(Assist.) deleted from Item

30187	30494	38200	38462	45221	45692
30479	30616	38203	38464	45236	45698
30481	30617	38206	38606	45239	45704
30484	32094	38209	39331	45560	45710
30485	32180	38212	45015	45572	45794
30490	34527	38213	45026	45581	
30491	34528	38256	45045	45652	
30493	37203	38460	45206	45669	

NOTES FOR GUIDANCE

Consultant Psychiatrist Attendances - Item 319

Add New Note:

Medicare benefits are attracted under Item 319 only where patients are diagnosed as suffering from:

- borderline personality disorder; or
- anorexia nervosa; or
- bulimia nervosa; or
- one of the following psychiatric illnesses arising from severe sexual or physical abuse:
  - dysthymic disorder;
  - substance- related disorder; or
  - somataform disorder

according to the relevant criteria set out in the Diagnostic and Statistical Manual of the American Psychiatric Association Fourth Edition (DSM-IV)

It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. The level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie. the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment.

In addition to the above diagnostic criteria and level of functional impairment, there is also a requirement that previous related psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy, less frequent but long term psychotherapy, pharmacological therapy, cognitive behaviour therapy. As a consequence, it is expected that patients would have been referred by a psychiatrist in the first instance.

It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. Fraudulent use of this item number may well lead to prosecution and financial penalties. The Health Insurance Commission will be closely monitoring the use of item 319.

When a patient who meets the criteria defined in item 319 attends a psychiatrist on more than 160 occasions in 12 months such attendances would be covered by items 310 to 318.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has undertaken to establish an appropriate mechanism to enable use of item 319 by suitably trained psychiatrists. In the interim it is expected that psychiatrists whose usual practice includes long term intensive treatment of patients whose diagnoses meet the criteria defined in the item will be using item 319.

On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in any 12 month period. In this regard the Health Insurance Commission will be monitoring providers' practice patterns with a view to the referral of possible cases of inappropriate practice to the Director of Professional Services Review. (See para 7.1 of the Notes for Guidance in the 1 November 1996 MBS Book).

Removal of Skin Lesions (Item 31200 - 31340)

Amend Note T8.10 to read:-

T8.10.1 The excision of warts and seborrheic keratoses attracts benefits on an attendance basis. Pre-malignant lesions are covered by Items 31200 to 31240.

T8.10.2 The excision of suspicious pigmented and other skin lesions for diagnostic purposes attract benefits under Items 31205 to 31240. Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

T8.10.3 Items 31200 and 31245 *do not require* specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that specimen be sent for histological examination. Items 31255 to 31335 *require* that specimen be sent for histological confirmation of malignancy which *must* be received before itemisation of accounts for Medicare benefits purposes.

T8.10.4 Where histological results are available at the time of issuing accounts, the histological diagnosis will decide the appropriate itemisation. If the histological report shows the lesion to be benign, Items 31205 to 31240 should be used. Malignant tumours are covered by Items 31255 to 31335.

T8.10.5 Item 31295 applies to the treatment of residual or recurrent BCCs or SCCs of the head and neck only, where performed by a specialist, or practitioner other than the practitioner who provided the previous treatment. Where the conditions of the item are not met, Items 31255 to 31290 are available to cover removal of residual or recurrent BCCs or SCCs .

T8.10.6 For the purposes of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

T8.10.7 Utilisation of the revised structure will be closely monitored and audited by the Health Insurance Commission to ensure appropriate usage of items. It will be necessary for practitioners to retain copies of histological reports.

Assistance at Cataract Surgery - Item 51318

The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

Prolonged Attendances - Items 160 to 164

Amend Note A.12 to read:-

A12.1 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 constant presence of the medical practitioner must be necessary for the treatment to be maintained; and

(iii) the attention rendered in that period must be to the exclusion of all other patients.

Assistance in the Administration of an Anaesthetic - Item 17503

Amend Note T5.1 to read:-

T5.1 General (Item 17503)

T5.1.1 A separate benefit is payable under Item 17503 for the services of an assistant anaesthetist in connection with an operation or combination of operations on a patient in imminent danger of death. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

T5.1.2 Situations where imminent danger of death requiring an assistant anaesthetist might arise include: complex airway problems, anaphylaxis or allergic reactions, malignant hyperpyrexia, neonatal and complicated paediatric anaesthesia, massive blood loss and subsequent resuscitation, intra-operative cardiac arrest, critically ill patients from intensive care units, inability to wean

critically ill patients from pulmonary bypass.

Regional or Field Nerve Blocks - Items 18210 to 18212

Benefits are payable under Items 18210 to 18212 in addition to the general anaesthetic for the related procedure.

DIAGNOSTIC IMAGING SERVICES (EFFECTIVE 19 JANUARY 1997)

Medicare Benefits Schedule Book - Category 5 - Diagnostic Imaging.
Amendments to Outline of Arrangements, Explanatory Notes, Schedule of Services, as set out in the 1 November 1996 Medicare Benefits Schedule Book.

Under the heading 'OUTLINE OF ARRANGEMENTS, DIA.1 Introduction':

- the sixth paragraph, the reference 'and all items in Subgroup I3.18 (Preparation)' should be changed to 'and all items in Subgroup I3.17 (Preparation)';

- the seventh paragraph, the reference 'and items in Subgroup I3.18' should be changed to 'and items in Subgroup I3.17'.

Amend paragraphs indicated:

- DIA.4.2. The paragraph deals with exemptions for a consultant physician or specialist. Delete the words 'A written request' and insert the words 'Except for R-type items in General Ultrasound (Group I1, Subgroup 1) which preclude in their description an exemption from the written request provisions, a written request'.

- DIA.4.7 1st paragraph, sub-paragraph (e). Delete '1997' and insert '1998'.

- DIA.4.7 3rd paragraph. Delete item 57718 from the list of exemptions for pre-existing diagnostic imaging practices.

- DIA.4.8 Delete item 57509 from the list of items that podiatrists may request.

Insert a new heading and text after paragraph DIA.5.3 as follows:-

DIA.6 Multiple Services Rules

The Multiple Services Rules apply to services rendered on or after 20 January 1997. There are three rules, and more than one rule may apply in a patient episode.

The rules do not apply to diagnostic imaging services rendered in a remote area by a practitioner who has a remote area exemption for that area. (See DIC. re Remote Area Exemptions).

Reference is made in these rules to "R-type" and "NR-type" services and an explanation of these services is set out in paragraph DIA.1 on page 331 of the 1 November 1996 Medicare Benefits Schedule Book.

Rule A. When more than one diagnostic imaging service, R-type or NR-type, is provided to a patient by the same practitioner on the one day, then:

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and

- the Schedule fee for each additional diagnostic imaging service is reduced by $5.

Rule B. When an R-type diagnostic imaging service and a consultation are rendered for a patient by the same practitioner

on the one day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee. The amount of the deduction will vary depending on the level of the Schedule fee for the consultation. The deductions are as follows:

- When the Schedule fee for the consultation is $40 or more:
  - the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $35; or
  - if the Schedule fee for the diagnostic imaging service with the highest Schedule fee is less than $35, the reduction will be the amount of that Schedule fee.
- When the Schedule fee for the consultation is less than $40:
  - the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $15.

The deduction under Rule B is made once only. If there is more than one consultation, the relevant consultation is that with the highest Schedule fee. There is no further deduction for additional consultations.

A 'consultation' is a service rendered under an item from Category 1 of the Medicare Benefits Schedule, that is, items 1 to 10815 inclusive.

Rule C. When an R-type diagnostic imaging service or services and a medical service are carried out for a patient by the same practitioner on the one day:

- the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by $5.

A deduction under Rule C is made once only. There is no further deduction for any additional medical services.

For Rule C, a 'medical service' is defined as any following item from the MBS:

- Category 2, items 11000 to 12533;
- Category 3, items 13020 to 51312 and items 17971(01) to 30000(299);
- Category 4, items 51700 to 53455;
- Cleft Lip and Palate services, items 75001 to 75854.

Pathology services are not included in Rule C.

When both Rules B and C apply, the sum of the deductions in the Schedule fee for the diagnostic imaging service with the highest Schedule fee is not to exceed that Schedule fee.

Amend paragraphs as indicated:

DIB.1.1 Delete the paragraph commencing 'A written request must also be dated and contain' with the following:

'A written request must also be dated and contain:

(i) the name and address or name and provider number in respect of the place of practice of the requesting practitioner; and

(ii) the indicator "A", to be shown on the request form, where the service requested is a pre-admission or post-discharge or outpatient type service that was part of a service:

(a) provided in the month prior to a patient's planned admission to hospital (either public or private) or day surgery facility that relates to that admission. This does not include the consultation at which it is decided to admit the patient to a hospital;

OR

(b) provided in the month following a patient's discharge from hospital (either public or private), or a day surgery facility that relates to that person's hospital/day surgery treatment;

OR

(c) provided to a patient who was referred or redirected to a doctor for treatment after presenting at an emergency or out-patient clinic at a public hospital;

OR

(d) provided at a public hospital in relation to a person who is not admitted to that hospital in connection with that service.'

Where the indicator "A" is shown on a request form, the account issued by the rendering medical practitioner must show the letter "A" on the account issued to the patient, or, where the service is bulk billed, the DBIC claim header should be used. The DBIC forms are available from the Health Insurance Commission.

Where a service is self determined by a medical practitioner, that medical practitioner must assess whether the service should be identified by the letter "A" , and if so, the accounts issued or bulk billed must be marked as referred to above.

- **EXPLANATORY NOTES**

Principles of Interpretation and Billing

Following sub-paragraph 2(b), the paragraph beginning 'This requirement relates specifically to R-type ultrasound services of...' items 55052 and 55058 should be added to the list and item 55054 should be deleted from the list.

Amendments to the Descriptions for some Items:

- Item 55210. Delete the words 'report is' in the phrase 'and that specialist interprets the results and report is prepares a report'.

- Item 58300. Omit the words 'STUDY, WRIST AND KNEE' and substitute the word 'STUDY'.

- Item 58939. Omit the words 'DEFAECOGRAM, paediatric', substitute the word 'DEFAECOGRAM'.

- Item 59751. Omit the words 'one joint' and substitute the words 'double contrast'.
- Item 60500. Insert after the words '..with general anaesthesia' the following '(not being a service associated with a radiographic examination)'.

- Item 60503. Insert after the words '...with general anaesthesia' the words '(not being a service associated with a radiographic examination)'.

- Group I5 - Nuclear Medicine Imaging. The Nuclear Medicine Imaging Group identifier has been changed from 'Group I5' to 'Group I4'. Consequential amendments should be made:

  - in the table of contents (page 330);
  - at DIK.1 General;
  - at DIK.2 Radiopharmaceuticals;
  - at DIK.3 Study of Region or Organ not covered by any other item in this Group (Item 61503);
  - in the heading on page 366.

- In the Note at the start of Group I4 - Nuclear Medicine Imaging (on page 366), delete the words 'consultant physician' and add after the word 'referral.' the words 'The term "medical specialist' means a medical practitioner recognised as a specialist or as a consultant physician under the Health Insurance Act 1973.'

- Item 61405. Omit the words 'OR with planar imaging and single photon emission tomography' and substitute the words 'OR with planar imaging or single photon emission tomography'.

- Item 61462. Omit the words 'separate occasion using the same' and insert the words 'subsequent occasion where no fee has been paid for the first investigation and there is no additional'.

$50 Gap

From 17 December 1996, the maximum gap for all direct billed out-of-hospital services was changed to $50 instead of the $30.20 that had applied from 1 November 1996. The 'gap' rises from $30.20 at a Schedule fee of $201.33 and reaches $50 where the Schedule fee is $333.33 or above.

The Government agreed to provide an offsetting adjustment to cover the reduction in Medicare benefits for diagnostic imaging services where the Schedule fee exceeds $201.33, for direct billed non-hospital services. The adjustments came into effect on 19 February 1997.

Set out at the back of the Supplement is a list of Diagnostic Imaging MBS item numbers, Schedule fees, and the 75% 85% - $50 maximum gap. The services subject to a Schedule fee increase are marked by an asterisk. The fee increase applies from 19 February 1997.

PATHOLOGY SERVICES (EFFECTIVE 20 MARCH 1997)

Histopathology items

A new set of histopathology items has been included in the Pathology Services Table (PST). The new set includes eight items (72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836) which relate to histopathology items previously covered by item 72801. They are defined in terms of complexity level and number of specimens.

In addition, there are six items (72846, 72847, 72851, 72852, 72855 and 72856) which cover add-on procedures (immunohistochemistry, electron microscopy and frozen section). These can be claimed in addition to the basic histopathology examination item when ordered by the requesting practitioner.

Subrule 14 (1)(d) has been added to prevent inappropriate claims being made for multiple unidentified specimens under new histopathology items.

Subrule 14(4) and 14(5) ensure that a Medicare benefit is payable for only one of the eight basic histopathology examination items (72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836) in a patient episode. If in a patient episode more than one histopathology examinations are performed on separate specimens of different complexity levels, a Medicare benefit is payable only for the service which has the highest schedule fee.

Subrule 14(6) specifies that the complexity levels of the various types of histopathology specimens, referred to in the eight new basic histopathology items, are prescribed in Part 4 of the PST.

Hepatitis items

Two new hepatitis items, 69280 and 69283, and minor amendments to six hepatitis items, have been included to cover some clinical scenarios which were not adequately provided for when the revised hepatitis items were included in the PST in 1996.

Item 69280 covers the determination of the immune status to Hepatitis B and testing for Hepatitis C, for patients at risk for hepatitis C whose hepatitis C status and immunity to hepatitis B both need assessment. Item 69283 covers investigation for hepatitis A and C in a patient with elevated transaminase levels, who is at risk of hepatitis C, and has symptoms of acute hepatitis.

Other changes

The reference to the Kleihauer test has been removed from item 65005 and two new items (65052 and 65053) have been included to cover tests used to detect Rh positive cells in the maternal circulation. Item 65052 covers the Kleihauer test and Item 65053 covers the flow cytometric test.

A new item 66322, has been included in the PST to permit pregnant women, with existing diabetes, to obtain Medicare benefits for up to six glycosylated haemoglobin tests performed in the year which includes their pregnancy.

A new ladder of items (66427 to 66432) have been introduced to cover the situation where the thyroid stimulating hormone test (66327) is performed in the same patient episode as one or more other hormone assays.

Patient Episode Initiation item 73911, which covers the collection of specimens from patients in their own homes and from patients in nursing homes and institutions, has been replaced with two separate items. Item 73910 covers the collection of specimens in patients' homes and item 73912 covers the collection of specimens in nursing homes and institutions.

Sub-provision 4(12)(d) has been amended to permit requesting practitioners monitoring patients undergoing treatment with either Clozaril or Ticlopidine hydrochloride to request up to six tests with a six month period on one request form.

The new and amended items and Rules were developed in co-operation with the Royal College of Pathologists of Australasia and the Australian Association of Pathology Practices.

PATHOLOGY RULES OF INTERPRETATION

PX. PATHOLOGY SERVICES TABLE

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

1. (1) In this table

"patient episode" means:

(a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under subsection 16A of the Act:

(i) on the same day; or
(ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;

whether the services:

(iii) are requested by 1 or more practitioners; or
(iv) are described in a single item or in more than 1 item; or
(v) are rendered by 1 Approved Pathology Practitioner or more than 1 Approved Pathology Practitioner; or
(vi) are rendered on the same or different days; or

(b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service;

"recognised pathologist" means a medical practitioner recognised as a specialist in pathology by a determination under section 3D or subsection 61(3) of the Act;

"serial examinations" means a series of 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 or cultures were requested on 1 or more request forms by the treating practitioner;

"the Act" means the Health Insurance Act 1973.

1. (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.

1. (3) A reference in this Table by number to an item that is not included in this Table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.

1. (4) A reference to a Group in the Table includes every item in that Group.

Precedence of items

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

(a) subrule (1) does not apply; and

(b) a service is described in 2 or more items;

only the item that provides the lower or lowest fee for the service applies to the service.

2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

Circumstances in which services rendered following 2 requests to be taken to have been rendered following 1 request

3. (1) In subrule 3(2), **"service"** includes assay, estimation and test.

3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) 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 the services are rendered by an Approved Pathology Practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item 66201, other than an estimation of fructosamine or lithium, if:

(a) 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

(b) 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

(c) 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; and

(d) the account for the service is endorsed "Rule 3 Exemption".

4. (2) Rule 3 does not apply to any of the following pathology services:

(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 described in item 65007 in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulfasalazine or penicillamine therapy of a patient;

(e) a service described 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;

if:

(g) under a request for a service, no more than 6 tests are requested; and

(h) the tests are performed within 6 months of the request; and

(i) the account for the service is endorsed "Rule 3 Exemption".

Item taken to refer only to the first service of a particular kind

5. For the purposes of an item in Group P1 (Haematology):

(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) if:

(i) tests (except tests mentioned in item 65023) are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item 65023) are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Certain items not to apply to a service referred by one pathology practitioner to another

6. (1) In this rule:

"designated pathology service" means a pathology service in respect of tests relating to a single patient episode that are:

(a) tests of the kind described in item 66235; or

(b) tests of the kind described in item 66405; or

(c) tests of the kind described in item 69229.

6. (2) This rule applies in respect of a designated pathology service where:

(a) an Approved Pathology Practitioner (**'practitioner A'**) in an Approved Pathology Authority:

(i) has been requested to render the designated pathology service; and

(ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more (but not all) of the tests included in the service; and

(iii) requests an Approved Pathology Practitioner (**'practitioner B'**) in another approved authority to render the test or tests that practitioner A is unable to render; and

(iv) renders each test included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made: and

(b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item 66239, 66415 or 69239.

6. (3) Where this rule applies in respect of a designated pathology service:

(a) item 66235, 66237, 66405, 66407, 66409, 66411, 66413, 69229, 69231, 69233, 69235 or 69237 (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

(b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) - subject to subrule (2B), the amount specified in item 66241, 66417 or 69241 (as the case requires) is payable for each test that the service comprises.

6. (4) For the purposes of paragraph (2A) (b), the maximum number of tests to which item 66241, 66417 or 69241 applies is:

(a) in the case of item 66241:

3 - **X**; or

(b) in the case of item 66417 or 69241:

6 - **X**

where **X** is the number of tests rendered by practitioner A in relation to the designated pathology service in respect of which the request mentioned in that paragraph is made.

6. (5) Items in Group P10 (Patient episode initiation) do not apply to the second-mentioned Approved Pathology Practitioner in subrule (2).

Items not to be split

7. Except as stated in rule 6, the amount specified in an item is payable only to one Approved Pathology Practitioner in respect of

a single patient episode.

Certain tests on stored material to be treated as part of the same patient episode

8. For the purposes of items in Group P2 (Chemical):

(a) if a pathology service that involves the measurement of a substance in urine requires calculation of a substance/creatinine ratio, the service is taken to include the measurement of creatinine necessary for the calculation; and

(b) If:

(i) tests are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Item 66317

9. The amount specified in item 66317 is not payable in respect of a pathology service described in the item unless at least one of the following paragraphs applies:

(a) if the HDL cholesterol or apolipoprotein B/A1 ratio of the patient is requested to be determined because the patient has a serum cholesterol level >5.5 mmol/l - the determination is performed on the sample that the serum cholesterol level determination for the patient was performed;

(b) if the HDL cholesterol or apolipoprotien B/A1 ratio of the patient is requested to be determined because the patient has a fasting serum triglyceride level >2.0 mmol/l - the determination is performed on the sample that the serum triglyceride level determination for the patient was performed;

(c) the pathologist who renders the service has a written statement from the medical practitioner who requested the service that the patient is on a lipid lowering drug.

Thyroid function testing

10. (1) For the purposes of item 66329:

"abnormal level of TSH" means a level of TSH that is outside the normal reference range in respect of the particular method of assay used to determine the level.

10. (2) Except where paragraph (a) of item 66329 is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

10. (3) The written statement from the medical practitioner must indicate:

(a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item 66329; or

(b) that the medical practitioner who requested the tests suspects the patient has a pituitary dysfunction; or

(c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

11. For the purposes of an item in Group P3 (Microbiology):

(a) **"serial examinations or cultures"** means a series of 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) if:

(i) tests are carried out in relation to a patient episode; and

(ii) specimen material from the patient episode is stored; and

(iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Investigation for hepatitis and syphilis serology

12. **(1)** A medicare benefit is not payable in respect of more than one of items 69266, 69267, 69268, 69269, 69270, 69271, 69272, 69273, 69274, 69275, 69276, 69277, 69278, 69279, 69280, 69281 and 69283 in a patient episode.

(2) For the purposes of items 69279 and 69283, **'currently elevated transaminase level'** means a level of alanine aminotransferase or aspartate aminotransferase above the normal reference range in respect of the particular method of assay used to determine the level, as disclosed by a test carried out on a sample taken for the investigation or on a sample taken within the previous 7 days.

Tests in Group P4 (Immunology) relating to antibodies

13. For the purposes of items in Group P4 (Immunology), in items 71119, 71121, 71123 and 71125, if:

(a) tests are carried out in relation to a patient episode; and
(b) specimen material from the patient episode is stored; and
(c) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

the later tests and the earlier tests are taken to be part of one patient episode.

Tests on biopsy material-Group P5 (Tissue Pathology) and Group P6 (Cytology)

14. (1) For the purposes of items in Group P5 (Tissue Pathology):

(a) **"biopsy material"** means all tissue (other than a bone marrow biopsy) received by the Approved Pathology Practitioner from an operation, or a group of operations, performed on a patient at the same time; and
(b) if:
  (i) a pathology service that comprises 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 taken to be 1 pathology service; and
(c) **"cytology"** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant, but in accordance with customary laboratory practice examination of a blood film and a bone marrow aspirate is excluded from this definition.
(d) **"Separately identified specimen"** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

14. (2) For the purposes of Groups P5 and P6 of the Pathology Services Table, services in Group P6 include any services described in Group P5 on the material submitted for a test in Group P6.

14. (3) For the purposes of subrule (2) - any sample submitted for cytology from which a cell block is prepared does not qualify for a Group P5 item.

14.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 are performed in a single patient episode, a medicare benefit is payable for the item performed that has the highest schedule fee.

14.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.

14.(6) In items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 a reference to a complexity level is a reference to a specimen type mentioned in Part 4 of this Table.

Items in Groups P10 (Patient episode initiation) and P11 (Specimen referred) not to apply in certain circumstances

15. (1) For the purposes of this rule and items in Groups P10 (Patient episode initiation) and P11 (Specimen referred);

"institution" means a place 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; but does not include:
(j) a hospital; or
(k) a nursing home; or
(l) accommodation for aged persons that is attached to a nursing home or situated within a nursing home complex;

"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 internal Territory; or
(c) an authority of a State or internal Territory; or
(d) 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.

15. (2) If a service described in an item in Group P10 or P11 is rendered by, or on behalf of, an Approved Pathology Practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:

(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 is made; or
(c) the pathology equipment of a recognised hospital, or a prescribed laboratory, is used in rendering the service; or
(d) a member of the staff of a recognised hospital, or a prescribed laboratory, participates in the service in the course of the member's employment with the hospital or laboratory.

15. (3) An item in Group P10 or P11 does not apply to a pathology service to which subsection 16A(7) of the Act applies.

15. (4) An item in Group P10 or P11 does not apply to a pathology service unless at least one item in Groups P1 to P8 also applies to that service.

15. (5) Subject to subrule (7), if one item in Group P10 applies to a patient episode, no other item in that Group applies to that patient episode.

15. (6) An item in Group P11 applies only to the Approved Pathology Practitioner or Approved Pathology Authority to whom the specimen mentioned in the item was referred.

15. (7) If, in respect of the same patient episode:

(a) services referred to in 1 or more items in Group P5 and one or more of Groups P1, P2, P3, P4, P6, P7 and P8 are rendered by an Approved Pathology Practitioner in the laboratory of another Approved Pathology Authority; and
(b) services referred to in 1 or more items in Group P6 and one or more of Groups P1, P2, P3, P4, P5, P7 and P8 are rendered by another Approved Pathology Practitioner in another Approved Pathology Authority;

the fee specified in the applicable item in Group P10 is payable to both Approved Pathology Practitioners.

15. (8) If more than one 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 or by a single Approved Pathology Authority;

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

15. (9) The amount specified in item 73921 is payable only once in respect of a single patient episode.

Application of an item in Group P11 (Specimen referred) to a service excludes certain other items

16. If item 73921 applies to a patient episode, none of the items in Group P10 applies to any pathology service rendered by the Approved Pathology Authority or approved pathology provider who claimed item 73921 in respect of that patient episode.

Circumstances in which an item in Group P11 (Specimen referred) does not apply

17. (1) An Item in Group P11 does not apply to a referral if:

(a) a service in respect of the same patient episode has been carried out by the referring Approved Pathology Authority; and
(b) the Approved Pathology Authority to which the referral is made is related to the referring Approved Pathology Authority.

17. (2) An Approved Pathology Authority is related to another Approved Pathology Authority for the purpose of subclause(1) if:

(a) both Approved Pathology Authorities are employed (including employed under contract) by the same person, whether or not that person is also an Approved Pathology Authority; or
(b) either of the Approved Pathology Authorities is employed (including employed under contract) by the other; or
(c) both of the Approved Pathology Authorities are corporations and are related corporations within the meaning of the Corporations Law; or
(d) the Approved Pathology Authorities are partners (whether or not either or both of the Approved Pathology Authorities are individuals and whether or not other persons are in partnership with either or both of the Approved Pathology Authorities).

Abbreviations

18. (1) The abbreviations in Part 3 of this Table may be used to identify particular pathology services or groups of pathology services.

18. (2) The names of services or drugs not listed in Part 3 of this Table must be written in full.

Certain pathology services to be treated as one service

19. (1) In this rule:

"general practitioner" means a medical practitioner who:
(a) is not a consultant physician in any specialty; and
(b) is not a specialist in any specialty;

"set of pathology services" means a group of pathology services:
(a) that consists of services that are described in at least 4 different items; and
(b) all of which are requested in a single patient episode; and

(c) each of which relates to a patient who is not an admitted patient of a hospital; and
(d) none of which is referred to in an item in:
(i) item 66241, 66417, 69241, 73053 or 73055; or
(ii) an item in Group P10 (Patient episode initiation) or Group P11 (Specimen referred).

19. (2) If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.

19. (3) If the fee specified in one item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service described in the first-mentioned item is to be treated as one pathology service; and
(b) either:
(i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as one pathology service; or
(ii) if 2 or more items that describe any of those services specify the second-highest fee - the pathology service described in the item that specifies the second-highest fee, and that has the lowest item number, is to be treated as one pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as one pathology service under paragraphs (a) and (b), are to be treated as one pathology service.

19. (4) If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
(a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as one pathology service; and
(b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as one pathology service; and
(c) the pathology services in the set, other than the services that are to be treated as one pathology service under paragraphs (a) and (b), are to be treated as one pathology service.

19. (5) If pathology services are to be treated as one pathology service under paragraph (3)(c) or paragraph (4)(c), the fee for the one pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the one pathology service.

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

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

If the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 May 1997 and continues beyond that date, the old (1 November 1996) item, fee and benefit levels will apply. In any other case the date the service is rendered will determine which item and fee is applicable.

	GROUP A5 - 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 attendance on the patient to the exclusion of all other patients - For a period of not less than 1 hour but less than 2 hours *(See para A.12 of explanatory notes to this Category)*
160	**Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
‡+	- For a period of not less than 2 hours but less than 3 hours *(See para A.12 of explanatory notes to this Category)*
161	**Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
‡+	- For a period of not less than 3 hours but less than 4 hours *(See para A.12 of explanatory notes to this Category)*
162	**Fee:** $350.00 **Benefit:** 75% = $262.50 85% = $300.00
‡+	- For a period of not less than 4 hours but less than 5 hours *(See para A.12 of explanatory notes to this Category)*
163	**Fee:** $450.00 **Benefit:** 75% = $337.50 85% = $400.00
‡+	- For a period of 5 hours or more *(See para A.12 of explanatory notes to this Category)*
164	**Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $450.00
	GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
▲	- An attendance of more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300 to 308 or 319 apply exceed 50 but not more than 160 attendances in a 12 month period and where the patient has: (i) a history of severe sexual or physical abuse which has led to psychiatric illness, or has been diagnosed as suffering from borderline personality disorder or anorexia nervosa or bulimia nervosa; and (ii) been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale; and (iii) a history of failed related psychiatric treatment.
319	**Fee:** $128.50 **Benefit:** 75% = $96.40 85% = $109.25
	GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)
‡	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, performed by a specialist or a consultant physician where the patient is referred by another medical practitioner, for either:- (a) the confirmation of *Helicobactor pylori* colonisation, where: (i) suitable biopsy material for diagnosis cannot be obtained at endoscopy in patients with peptic ulceration, or where the diagnosis of peptic ulcer has been made on barium meal; or (ii) in patients with past history of peptic ulceration, gastric ulceration or gastric lymphoma, where endoscopy is not indicated, OR (b) the monitoring of the success or eradication of *Helicobactor pylori* in patients with peptic ulceration
12533	**Fee:** $62.10 **Benefit:** 75% = $46.60 85% = $52.80
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 2 - DIALYSIS
†	TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes. 17708 = 6B + 2T)
13110	**Fee:** $167.75 **Benefit:** 75% = $125.85 85% = $142.60

@ 13112	PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes. 17708 = 6B + 2T) **Fee:** $100.35 **Benefit:** 75% = $75.30 85% = $85.30
	SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES
† 13290	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
† 13292	SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital or approved day-hospital facility (Anaes. 17708 = 4B + 4T) **Fee:** $300.00 **Benefit:** 75% = $225.00 85% = $255.00
	SUBGROUP 4 - PAEDIATRIC & NEONATAL
† 13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes. 17709 = 5B + 4T) **Fee:** $167.00 **Benefit:** 75% = $125.25 85% = $141.95
	SUBGROUP 8 - HAEMATOLOGY
† 13757	THERAPEUTIC VENESECTION for the management of haemochromatosis or polycythemia vera **Fee:** $53.60 **Benefit:** 75% = $40.20 85% = $45.60
‡ 13760	IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for: . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; . small round cell sarcomas; . primitive neuroectodermal tumour; . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; or . germ cell tumours which have had an incomplete response to first line therapy. - performed under the supervision of a consultant physician - each day. **Fee:** $560.00 **Benefit:** 75% = $420.00 85% = $510.00
	SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT
@ 13818	RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes. 17705 = 3B + 2T) *(See para T1.8 of explanatory notes to this Category)* **Fee:** $83.55 **Benefit:** 75% = $62.70 85% = $71.05
@ 13845	COUNTERPULSATION BY INTRA-AORTIC BALLOON - management on the first day, including percutaneous insertion, initial and subsequent consultations and monitoring of parameters (Anaes. 17710 = 8B + 2T) **Fee:** $397.20 **Benefit:** 75% = $297.90 85% = $347.20

	SUBGROUP 12 - DERMATOLOGY
‡ 14106	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm² (Anaes. 17707 = 5B + 2T) *(See para T1.11 of explanatory notes to this Category)* **Fee:** $112.00 **Benefit:** 75% = $84.00 85% = $95.20
‡ 14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm² and up to 100cm² (Anaes. 17708 = 5B + 3T) *(See para T1.11 of explanatory notes to this Category)* **Fee:** $137.45 **Benefit:** 75% = $103.10 85% = $116.85
‡ 14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm² and up to 150cm² (Anaes. 17709 = 5B + 4T) *(See para T1.11 of explanatory notes to this Category)* **Fee:** $162.90 **Benefit:** 75% = $122.20 85% = $138.50
‡ 14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm² and up to 250cm² (Anaes. 17710 = 5B + 5T) *(See para T1.11 of explanatory notes to this Category)* **Fee:** $188.35 **Benefit:** 75% = $141.30 85% = $160.10
‡ 14118	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 apply) in any 12 month period - area of treatment more than 250cm² (Anaes. 17711 = 5B + 6T) *(See para T1.11 of explanatory notes to this Category)* **Fee:** $239.25 **Benefit:** 75% = $179.45 85% = $203.40
	SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES
@ 14203	HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes. 17706 = 4B + 2T) **Fee:** $37.55 **Benefit:** 75% = $28.20 85% = $31.95
	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
†	Administration of Strontium 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain
16015	**Fee:** $3,000.00 **Benefit:** 75% =$2,250.00 85% =$2,950.00
	GROUP T5 - ASSISTANCE IN THE ADMINISTRATION OF AN ANAESTHETIC
†	Assistance in the administration of an anaesthetic requiring continuous anaesthesia on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients *(See para T5.1 of explanatory notes to this Category)*
17503	**Derived Fee:** 30% of the fee for the administration of the anaesthetic

	GROUP T6 - ANAESTHETICS
	SUBGROUP 2 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A MEDICAL SERVICE
‡ 18016	- In connection with a regional or field nerve block covered by items 18216, 18219, 18230, 18232, 18233, 18234, 18236, 18242, 18280, 18284, 18286, 18288, 18290, 18292, 18294, 18296 or 18298, not being an anaesthetic administered in conjunction with an operative procedure (Anaes. = 4B + 4T) **Fee:** $111.60 **Benefit:** 75% = $83.70 85% = $94.90
	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS
† 18210	Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **OR** sciatic nerves, in conjunction with knee surgery **Fee:** $32.60 **Benefit:** 75% = $24.45 85% = $27.75
† 18211	Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the femoral **AND** sciatic nerves, in conjunction with knee surgery **Fee:** $39.10 **Benefit:** 75% = $29.35 85% = $33.25
† 18212	Introduction of a regional or field nerve block peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery **Fee:** $32.60 **Benefit:** 75% = $24.45 85% = $27.75
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
A 30023	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field block, including suturing of that wound when performed (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $239.40 **Benefit:** 75% = $179.55 85% = $203.50
A 30067 G 30068 S	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $164.20 **Benefit:** 75% = $123.15 85% = $139.60 **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75
A 30110 G 30111 S	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $208.75 **Benefit:** 75% = $156.60 85% = $177.45 **Fee:** $272.75 **Benefit:** 75% = $204.60 85% = $231.85
A 30168	LIPECTOMY - wedge excision of skin or fat not being a service to which item 30165 applies - 1 EXCISION (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $334.00 **Benefit:** 75% = $250.50 85% = $284.00
A 30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser, requiring admission to a hospital or day hospital facility, or when performed by a specialist in the practice of his/her specialty, where the time taken is greater than 45 minutes (5 or more warts) (Anaes. 17707 = 3B + 4T) **Fee:** $188.70 **Benefit:** 75% = $141.55 85% = $160.40
@ 30196	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes. 17706 = 4B + 2T) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $92.75 **Benefit:** 75% = $69.60 85% = $78.85

@ 30197	CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 or more lesions) (Anaes. 17708 = 4B + 4T) *(See para T8.13 of explanatory notes to this Category)* **Fee:** $323.10 **Benefit:** 75% = $242.35 85% = $274.65
@ 30205	CANCER OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE CANCER EXTENDS INTO CARTILAGE (Anaes. 17706 = 4B + 2T) **Fee:** $92.75 **Benefit:** 75% = $69.60 85% = $78.85
@ 30207	SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes. 17706 = 4B + 2T) **Fee:** $32.75 **Benefit:** 75% = $24.60 85% = $27.85
@ 30213	TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes. 17707 = 5B + 2T) *(See para T8.14 of explanatory notes to this Category)* **Fee:** $80.65 **Benefit:** 75% = $60.50 85% = $68.60
† 30255	SUBMANDIBULAR DUCTS, removal of, for surgical control of drooling (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $815.50 **Benefit:** 75% = $611.65 85% = $765.50
A 30341G 30342S	BREAST, excision of CYST, fibro adenoma or other lesion or segmental resection for any other reason (Anaes. 17705 = 3B + 2T) (Assist.) **Fee:** $144.75 **Benefit:** 75% = $108.60 85% = $123.05 **Fee:** $188.25 **Benefit:** 75% = $141.20 85% = $160.05
† 30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $384.50 **Benefit:** 75% = $288.40 85% = $334.50
@ 30406	PARACENTESIS ABDOMINIS (Anaes. 17708 = 6B + 2T) **Fee:** $38.30 **Benefit:** 75% = $28.75 85% = $32.60
† 30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy (Anaes. 17720 = 7B + 13T) **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $550.00
A 30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (Anaes. 17711 = 5B + 6T) **Fee:** $349.55 **Benefit:** 75% = $262.20 85% = $299.55
A 30481	PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (initial procedure) (Anaes. 17711 = 5B + 6T) **Fee:** $262.15 **Benefit:** 75% = $196.65 85% = $222.85
A 30484	ENDOSCOPIC RETROGRADE CHOLANGIO-PANCREATOGRAPHY (Anaes. 17708 = 5B + 3T) **Fee:** $267.95 **Benefit:** 75% = $201.00 85% = $227.80
A 30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes. 17708 = 5B + 3T) **Fee:** $413.60 **Benefit:** 75% = $310.20 85% = $363.60
A 30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes. 17710 = 6B + 4T) **Fee:** $386.50 **Benefit:** 75% = $289.90 85% = $336.50
A 30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes. 17711 = 5B + 6T) **Fee:** $407.75 **Benefit:** 75% = $305.85 85% = $357.75
A 30493	BILIARY MANOMETRY (Anaes. 17709 = 5B + 4T) **Fee:** $244.65 **Benefit:** 75% = $183.50 85% = $208.00
A 30494	ENDOSCOPIC BILIARY DILATATION (Anaes. 17711 = 5B + 6T) **Fee:** $308.70 **Benefit:** 75% = $231.55 85% = $262.40

A 30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes. 17711 = 7B + 4T) (Assist.) **Fee:** $341.00 **Benefit:** 75% = $255.75 85% = $291.00
A 30612 G 30614 S	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45 **Fee:** $341.00 **Benefit:** 75% = $255.75 85% = $291.00
A 30616 G 30617 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes. 17707 = 4B + 3T) **Fee:** $194.85 **Benefit:** 75% = $146.15 85% = $165.65 **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
A 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 (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $172.60 **Benefit:** 75% = $129.45 85% = $146.75 **Fee:** $214.35 **Benefit:** 75% = $160.80 85% = $182.20
A 30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $219.90 **Benefit:** 75% = $164.95 85% = $186.95 **Fee:** $299.25 **Benefit:** 75% = $224.45 85% = $254.40
A 30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $382.70 **Benefit:** 75% = $287.05 85% = $332.70
@ 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 (Anaes. 17707 = 4B + 3T) **Fee:** $426.50 **Benefit:** 75% = $319.90 85% = $376.50
@ 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 (inclusive) (Anaes. 17708 = 4B + 4T) **Fee:** $533.15 **Benefit:** 75% = $399.90 85% = $483.15
@ 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 (Anaes. 17712 = 4B + 8T) **Fee:** $639.75 **Benefit:** 75% = $479.85 85% = $589.75
† 31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service to which another item in this Group applies *(See para T8.10 of explanatory notes to this Category)* **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25
* ‡ 31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size up to 10mm in diameter, **removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17706 = 4B + 2T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $70.00 **Benefit:** 75% = $52.50 85% = $59.50

* ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 10mm and up to 20mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17706 = 4B + 2T) *(See para T8.10 of explanatory notes to this Category)* 31210 **Fee:** $105.00 **Benefit:** 75% = $78.75 85% = $89.25
* ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size more than 20mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17706 = 4B + 2T) *(See para T8.10 of explanatory notes to this Category)* 31215 **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
* ‡	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to 10mm in diameter, removal of 4 to 10 lesions by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31220 **Fee:** $157.50 **Benefit:** 75% = $118.15 85% = $133.90
* ‡	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), **lesion size up to 10mm in diameter, removal of more than 10 lesions by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excison to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17713 = 4B + 9T) *(See para T8.10 of explanatory notes to this Category)* 31225 **Fee:** $280.00 **Benefit:** 75% = $210.00 85% = $238.00
* ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from nose, eyelid, lip, ear, digit or genitalia,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17708 = 5B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31230 **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
* ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to 10mm in diameter** - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31235 **Fee:** $122.50 **Benefit:** 75% = $91.90 85% = $104.15
* ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where specimen sent for histological examination*** (not being a service to which item 30195 applies) (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31240 **Fee:** $143.50 **Benefit:** 75% = $107.65 85% = $122.00
* ‡	SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HYDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes. 17710 = 4B + 6T) *(See para T8.10 of explanatory notes to this Category)* 31245 **Fee:** $315.00 **Benefit:** 75% = $236.25 85% = $267.75

*‡ 31250	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface where the specimen is sent for histological confirmation of diagnosis (Anaes. 17710 = 4B + 6T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $315.00 **Benefit:** 75% = $236.25 85% = $267.75
*‡ 31255	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter** - where removal is by surgical excision and suture ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 5B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $189.00 **Benefit:** 75% = $141.75 85% = $160.65
*‡ 31260	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 5B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $269.50 **Benefit:** 75% = $202.15 85% = $229.10
*‡ 31265	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $157.50 **Benefit:** 75% = $118.15 85% = $133.90
*‡ 31270	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $220.50 **Benefit:** 75% = $165.40 85% = $187.45
*‡ 31275	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 4B + 4T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $255.50 **Benefit:** 75% = $191.65 85% = $217.20
*‡ 31280	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $133.00 **Benefit:** 75% = $99.75 85% = $113.05
*‡ 31285	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $182.00 **Benefit:** 75% = $136.50 85% = $154.70
*‡ 31290	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, tumour size more than 20mm in diameter** - where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 4B + 4T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $210.00 **Benefit:** 75% = $157.50 85% = $178.50

†	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, residual or recurrent (where lesion treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), ***performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment***, removal from the head or neck (anterior to the sternomastoid muscles), where removal is by **surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 5B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31295 **Fee:** $250.00 **Benefit:** 75% = $187.50 85% = $212.50
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 5B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31300 **Fee:** $273.00 **Benefit:** 75% = $204.75 85% = $232.05
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 5B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31305 **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $286.00
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31310 **Fee:** $238.00 **Benefit:** 75% = $178.50 85% = $202.30
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to 20mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31315 **Fee:** $301.00 **Benefit:** 75% = $225.75 85% = $255.85
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 4B + 4T) *(See para T8.10 of explanatory notes to this Category)* 31320 **Fee:** $336.00 **Benefit:** 75% = $252.00 85% = $286.00
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31300* and *31310* - tumour size up to 10mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31325 **Fee:** $231.00 **Benefit:** 75% = $173.25 85% = $196.35
* ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31315* - tumour size more than 10mm and up to 20mm in diameter** - where removal is by **definitive surgical excision and suture** ***and histological confirmation of malignancy has been obtained*** (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* 31330 **Fee:** $273.00 **Benefit:** 75% = $204.75 85% = $232.05

*‡ 31335	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** - where removal is by **definitive surgical excision and suture *and histological confirmation of malignancy has been obtained*** (Anaes. 17708 = 4B + 4T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $315.00 **Benefit:** 75% = $236.25 85% = $267.75
*‡ 31340	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item.* MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, performed in association with excision of malignant tumour of skin covered by item **31255, 31260, 31265, 31270, 31275, 31280, 31285, 31290, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330, 31335** (Anaes. 17710 = 4B + 6T) *(See para T8.10 of explanatory notes to this Category)* **Derived Fee:** 75% of the fee for excision of malignant tumour
† 31345	LIPOMA, excision of, where lesion is subcutaneous and **greater than 50mm in diameter**, or is sub-fascial (Anaes. 17707 = 4B + 3T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $180.00 **Benefit:** 75% = $135.00 85% = $153.00
† 31350	BENIGN TUMOUR of SOFT TISSUE, removal of by surgical excision, where ***specimen is sent for histological confirmation of diagnosis***, not being a service to which another item in this Group applies (Anaes. 17708 = 4B + 4T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $370.00 **Benefit:** 75% = $277.50 85% = $320.00
† 31355	MALIGNANT TUMOUR of SOFT TISSUE, removal of by surgical excision, where ***histological proof of malignancy has been obtained***, not being a service to which another item in this Group applies (Anaes. 17710 = 5B + 5T) *(See para T8.10 of explanatory notes to this Category)* **Fee:** $610.00 **Benefit:** 75% = $457.50 85% = $560.00
	SUBGROUP 2 - COLORECTAL
A 32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes. 17723 = 8B + 15T) (Assist.) **Fee:** $1,106.80 **Benefit:** 75% = $830.10 85% =$1,056.80
A 32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR - excision of (Anaes. 17720 = 8B + 12T) (Assist.) **Fee:** $1,403.85 **Benefit:** 75% =$1,052.90 85% =$1,353.85
A 32039	RECTUM AND ANUS, ABDOMINO-PERINEAL RESECTION OF - 1 surgeon (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,127.20 **Benefit:** 75% = $845.40 85% =$1,077.20
A 32042	RECTUM AND ANUS, ABDOMINO-PERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION - abdominal resection (Anaes. 17724 = 10B + 14T) (Assist.) **Fee:** $949.50 **Benefit:** 75% = $712.15 85% = $899.50
A 32045	RECTUM AND ANUS, ABDOMINO-PERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION - perineal resection (Assist.) **Fee:** $355.40 **Benefit:** 75% = $266.55 85% = $305.40
A 32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) **Fee:** $549.10 **Benefit:** 75% = $411.85 85% = $499.10
A 32047	PERINEAL PROCTECTOMY (Anaes. 17717 = 7B + 10T) (Assist.) **Fee:** $639.75 **Benefit:** 75% = $479.85 85% = $589.75
A 32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy - 1 surgeon (Anaes. 17737 = 10B + 27T) (Assist.) **Fee:** $1,701.00 **Benefit:** 75% =$1,275.75 85% =$1,651.00

A 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) (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,561.15 **Benefit:** 75% =$1,170.90 85% =$1,511.15
A 32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir - conjoint surgery, perineal surgeon (Assist.) **Fee:** $413.60 **Benefit:** 75% = $310.20 85% = $363.60
A 32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy - 1 surgeon (Anaes. 17730 = 10B + 20T) (Assist.) **Fee:** $1,701.00 **Benefit:** 75% =$1,275.75 85% =$1,651.00
A 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) (Anaes. 17726 = 10B + 16T) (Assist.) **Fee:** $1,561.15 **Benefit:** 75% =$1,170.90 85% =$1,511.15
A 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 (Assist.) **Fee:** $413.60 **Benefit:** 75% = $310.20 85% = $363.60
A 32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes. 17708 = 4B + 4T) **Fee:** $405.15 **Benefit:** 75% = $303.90 85% = $355.15
A 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 (Anaes. 17706 = 4B + 2T) (Assist.) **Fee:** $188.70 **Benefit:** 75% = $141.55 85% = $160.40
† 32115	RECTAL STRICTURE, dilatation of (Anaes. 17706 = 4B + 2T) **Fee:** $93.20 **Benefit:** 75% = $69.90 85% = $79.25
† 32139	HAEMORRHOIDECTOMY involving third or fourth degree haemorrhoids, including excision of anal skin tags when performed (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $270.00 **Benefit:** 75% = $202.50 85% = $229.50
A 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 (Anaes. 17708 = 4B + 4T) **Fee:** $188.70 **Benefit:** 75% = $141.55 85% = $160.40
† 32200	DISTAL MUSCLE, devascularisation of (Anaes. 17712 = 4B + 8T) (Assist.) **Fee:** $217.10 **Benefit:** 75% = $162.85 85% = $184.55
† 32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes. 17717 = 4B + 13T) (Assist.) **Fee:** $466.25 **Benefit:** 75% = $349.70 85% = $416.25
† 32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes. 17715 = 4B + 11T) (Assist.) **Fee:** $421.20 **Benefit:** 75% = $315.90 85% = $371.20
† 32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes. 17723 = 4B + 19T) (Assist.) **Fee:** $676.85 **Benefit:** 75% = $507.65 85% = $626.85
† 32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital or approved day-hospital facility, excluding aftercare (Anaes. 17705 = 3B + 2T) **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00

	SUBGROUP 3 - VASCULAR
@	**VARICOSE VEINS**
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes. 17705 = 3B + 2T) **Fee:** $80.65 **Benefit:** 75% = $60.50 85% = $68.60
A 32508	VARICOSE VEINS, complete dissection at the sapheno-femoral or sapheno-popliteal junction, with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $391.80 **Benefit:** 75% = $293.85 85% = $341.80
A 32511	VARICOSE VEINS, complete dissection at the sapheno-femoral and sapheno-popliteal junction, with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $582.50 **Benefit:** 75% = $436.90 85% = $532.50
A 32514	VARICOSE VEINS, ligation of the long or short saphenous vein, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $680.45 **Benefit:** 75% = $510.35 85% = $630.45
A 32517	VARICOSE VEINS, ligation of the long and short saphenous vein, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes. 17713 = 3B + 10T) (Assist.) **Fee:** $876.30 **Benefit:** 75% = $657.25 85% = $826.30
A 34527	CENTRAL VEIN CATHETERISATION by open technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes. 17711 = 5B + 6T) **Fee:** $405.00 **Benefit:** 75% = $303.75 85% = $355.00
A 34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivey device (Anaes. 17709 = 5B + 4T) **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
	SUBGROUP 4 - GYNAECOLOGICAL
A 35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $255.85 **Benefit:** 75% = $191.90 85% = $217.50
‡ 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, 35657, 35673, 35750 or 35753 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, 35657, 35673, 35750 or 35753 applies (Anaes. 17709 = 4B + 5T) (Assist.) **Fee:** $393.55 **Benefit:** 75% = $295.20 85% = $343.55
† 35600	STRESS INCONTINENCE, VAGINAL PROCEDURE FOR (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $384.50 **Benefit:** 75% = $288.40 85% = $334.50
† 35612	CERVIX, RESIDUAL STUMP, removal of, by abdominal approach (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $371.55 **Benefit:** 75% = $278.70 85% = $321.55
† 35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes. 17711 = 6B + 5T) (Assist.) **Fee:** $297.25 **Benefit:** 75% = $222.95 85% = $252.70

A 35636	HYSTEROSCOPY, and laparoscopy where performed, under general anaesthesia involving either myomectomy or resection of uterine septum or both (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $318.00 **Benefit:** 75% = $238.50 85% = $270.30
† 35710	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $340.20 **Benefit:** 75% = $255.15 85% = $290.20
† 35750	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $576.15 **Benefit:** 75% = $432.15 85% = $526.15
† 35753	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, with salpingectomy, oophorectomy or excision of ovarian cyst, one or both sides, including any associated laparoscopy (Anaes. 17719 = 6B + 13T) (Assist.) **Fee:** $637.10 **Benefit:** 75% = $477.85 85% = $587.10
† 35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $576.15 **Benefit:** 75% = $432.15 85% = $526.15

	SUBGROUP 5 - UROLOGICAL
A 36549	URETEROLITHOTOMY (Anaes. 17713 = 7B + 6T) (Assist.) **Fee:** $611.65 **Benefit:** 75% = $458.75 85% = $561.65
† 36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes. 17714 = 7B + 7T) **Fee:** $196.50 **Benefit:** 75% = $147.40 85% = $167.05
A 36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes. 17719 = 7B + 12T) (Assist.) **Fee:** $782.90 **Benefit:** 75% = $587.20 85% = $732.90
A 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 (Anaes. 17718 = 7B + 11T) (Assist.) **Fee:** $697.30 **Benefit:** 75% = $523.00 85% = $647.30
† 36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes. 17707 = 3B + 4T) **Fee:** $237.40 **Benefit:** 75% = $178.05 85% = $201.80
† 37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes. 17722 = 6B + 16T) (Assist.) **Fee:** $1,049.05 **Benefit:** 75% = $786.80 85% = $999.05
A 37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854, 37207, 37208, 37303, 37321 or 37324 applies (Anaes. 17710 = 6B + 4T) **Fee:** $765.20 **Benefit:** 75% = $573.90 85% = $715.20
† 37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes. 17707 = 3B + 4T) **Fee:** $151.45 **Benefit:** 75% = $113.60 85% = $128.75
A 37372	URETHRAL DIVERTICULUM, excision of (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $342.50 **Benefit:** 75% = $256.90 85% = $292.50
A 37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $850.20 **Benefit:** 75% = $637.65 85% = $800.20
A 37438	SCROTUM, partial excision of (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $203.05 **Benefit:** 75% = $152.30 85% = $172.60
A 37616	VASO-VASOSTOMY or VASO-EPIDIDYMOSTOMY, unilateral, using operating microscope, for other than reversal of previous sterilisation (Anaes. 17712 = 3B + 9T) (Assist.) **Fee:** $507.70 **Benefit:** 75% = $380.80 85% = $457.70
A 37821	HYPOSPADIAS, distal, 1 stage repair (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $611.65 **Benefit:** 75% = $458.75 85% = $561.65
A 37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes. 17711 = 3B + 8T) (Assist.) **Fee:** $850.55 **Benefit:** 75% = $637.95 85% = $800.55
A 37827	HYPOSPADIAS, staged repair, first stage (Anaes. 17709 = 3B + 6T) (Assist.) **Fee:** $391.80 **Benefit:** 75% = $293.85 85% = $341.80
	SUBGROUP 6 - CARDIO-THORACIC
	MISCELLANEOUS CARDIAC PROCEDURES
A 38200	RIGHT HEART CATHERISATION, including fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection and exercise stress test (Anaes. 17712 = 7B + 5T) **Fee:** $327.10 **Benefit:** 75% = $245.35 85% = $278.05

A 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 (Anaes. 17712 = 7B + 5T) **Fee:** $390.30 **Benefit:** 75% = $292.75 85% = $340.30
A 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 (Anaes. 17714 = 7B + 7T) **Fee:** $471.85 **Benefit:** 75% = $353.90 85% = $421.85
A 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 or 38213 applies (Anaes. 17719 = 7B + 12T) **Fee:** $605.80 **Benefit:** 75% = $454.35 85% = $555.80
A 38212	CARDIAC ELECTROPHYSIOLOGICAL STUDY - 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous anti-arrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intra-operative mapping; or electrophysiological services during defibrillator implantation - not being a service associated with a service to which item 38209 or 38213 applies (Anaes. 17727 = 7B + 20T) **Fee:** $1,007.75 **Benefit:** 75% = $755.85 85% = $957.75
A 38213	CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes. 17711 = 7B + 4T) **Fee:** $300.00 **Benefit:** 75% = $225.00 85% = $255.00
‡ 38253	PERMANENT PACEMAKER, insertion, removal or replacement of (Anaes. 17710 = 6B + 4T) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $187.55 **Benefit:** 75% = $140.70 85% = $159.45
A 38256	TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes. 17710 = 6B + 4T) **Fee:** $196.15 **Benefit:** 75% = $147.15 85% = $166.75
‡ 38259	PERMANENT DUAL CHAMBER TRANSVENOUS ELECTRODES, insertion, removal, or replacement of (Anaes. 17713 = 6B + 7T) *(See para T8.26 of explanatory notes to this Category)* **Fee:** $614.85 **Benefit:** 75% = $461.15 85% = $564.85
† 38270	BALLOON VALVULOPLASTY OR SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes. 17728 = 20B + 8T) **Fee:** $669.90 **Benefit:** 75% = $502.45 85% = $619.90
† 38275	MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes. 17710 = 7B + 3T) **Fee:** $219.00 **Benefit:** 75% = $164.25 85% = $186.15
‡ 38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes. 17724 = 13B + 11T) (Assist.) **Fee:** $1,124.90 **Benefit:** 75% = $843.70 85% =$1,074.90
A 38460	STERNAL WIRE OR WIRES, removal of (Anaes. 17709 = 5B + 4T) **Fee:** $202.15 **Benefit:** 75% = $151.65 85% = $171.85
A 38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes. 17710 = 5B + 5T) **Fee:** $239.70 **Benefit:** 75% = $179.80 85% = $203.75
A 38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes. 17711 = 5B + 6T) **Fee:** $260.50 **Benefit:** 75% = $195.40 85% = $221.45

‡	*PACEMAKER PROCEDURES*
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes. 17721 = 15B + 6T) (Assist.) **Fee:** $703.70 **Benefit:** 75% = $527.80 85% = $653.70
A 38606	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes. 17711 = 8B + 3T) **Fee:** $282.60 **Benefit:** 75% = $211.95 85% = $240.25
	SUBGROUP 7 - NEUROSURGICAL
@ 39003	CISTERNAL PUNCTURE (Anaes. 17707 = 5B + 2T) **Fee:** $62.95 **Benefit:** 75% = $47.25 85% = $53.55
@ 39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes. 17707 = 5B + 2T) **Fee:** $117.05 **Benefit:** 75% = $87.80 85% = $99.50
A 39128	AUTOMATED SUBCUTANEOUS INFUSION DEVICE AND SPINAL CATHETER, insertion of (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $484.55 **Benefit:** 75% = $363.45 85% = $434.55
† 39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions **Fee:** $215.00 **Benefit:** 75% = $161.25 85% = $182.75
A 39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes. 17705 = 3B + 2T) **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75
A 40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $386.50 **Benefit:** 75% = $289.90 85% = $336.50
	SUBGROUP 8 - EAR, NOSE AND THROAT
† 41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $1,403.85 **Benefit:** 75% =$1,052.90 85% =$1,353.85
† 41672	NASAL SEPTUM, reconstruction of (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $442.75 **Benefit:** 75% = $332.10 85% = $392.75
† 41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes. 17708 = 6B + 2T) **Fee:** $167.75 **Benefit:** 75% = $125.85 85% = $142.60
† 41868	LARYNGEAL WEB, division of, using microlaryngoscopic techniques (Anaes. 17711 = 6B + 5T) **Fee:** $285.40 **Benefit:** 75% = $214.05 85% = $242.60
† 41869	BOTULINUM TOXIN INJECTION INTO VOCAL CORDS, including associated consultation **Fee:** $196.00 **Benefit:** 75% = $147.00 85% = $166.60
	SUBGROUP 9 - OPHTHALMOLOGY
@ 42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes. 17707 = 5B + 2T) **Fee:** $86.10 **Benefit:** 75% = $64.60 85% = $73.20
† 42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation **Fee:** $104.25 **Benefit:** 75% = $78.20 85% = $88.65

† 42670	PHOTOTHERAPEUTIC KERATECTOMY by excimer laser **Fee:** $400.00 **Benefit:** 75% = $300.00 85% = $350.00
† 42676	CONJUNCTIVA, biopsy of, as an independent procedure **Fee:** $85.00 **Benefit:** 75% = $63.75 85% = $72.25
@ 42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS (Anaes. 17711 = 6B + 5T) **Fee:** $660.90 **Benefit:** 75% = $495.70 85% = $610.90
† 42807	PHOTOMYDRIASIS, laser **Fee:** $261.20 **Benefit:** 75% = $195.90 85% = $222.05
† 42808	PHOTOIRIDOSYNERESIS, laser **Fee:** $261.20 **Benefit:** 75% = $195.90 85% = $222.05
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
A 45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes. 17708 = 3B + 5T) **Fee:** $220.85 **Benefit:** 75% = $165.65 85% = $187.75
A 45026	CARBON DIOXIDE LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or cystic acne - more than 1 aesthetic area (Anaes. 17705 = 3B + 2T) *(See para T8.42 of explanatory notes to this Category)* **Fee:** $292.60 **Benefit:** 75% = $219.45 85% = $248.75
A 45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes. 17711 = 5B + 6T) **Fee:** $226.40 **Benefit:** 75% = $169.80 85% = $192.45
A 45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals (Anaes. 17711 = 5B + 6T) **Fee:** $281.60 **Benefit:** 75% = $211.20 85% = $239.40
A 45221	DIRECT FLAP REPAIR, small (cross finger or similar), first stage (Anaes. 17706 = 3B + 3T) **Fee:** $192.05 **Benefit:** 75% = $144.05 85% = $163.25
A 45236	INDIRECT FLAP OR TUBED PEDICLE, spreading of pedicle, as a separate procedure (Anaes. 17708 = 3B + 5T) **Fee:** $272.75 **Benefit:** 75% = $204.60 85% = $231.85
A 45239	DIRECT, INDIRECT OR LOCAL FLAP, revision of (Anaes. 17707 = 3B + 4T) **Fee:** $192.05 **Benefit:** 75% = $144.05 85% = $163.25
† 45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $469.00 **Benefit:** 75% = $351.75 85% = $419.00
A 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 (Anaes. 17712 = 5B + 7T) **Fee:** $347.85 **Benefit:** 75% = $260.90 85% = $297.85
A 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 (Anaes. 17709 = 3B + 6T) **Fee:** $214.25 **Benefit:** 75% = $160.70 85% = $182.15
A 45581	FACIAL NERVE PALSY, excision of tissue for (Anaes. 17709 = 5B + 4T) **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75

A 45623	PTOSIS of eyelid (unilateral), correction of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $570.65 **Benefit:** 75% = $428.00 85% = $520.65
A 45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $939.45 **Benefit:** 75% = $704.60 85% = $889.45
A 45652	RHINOPHYMA, carbon dioxide laser excision-ablation of (Anaes. 17710 = 5B + 5T) **Fee:** $261.65 **Benefit:** 75% = $196.25 85% = $222.45
A 45656	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes. 17712 = 5B + 7T) (Assist.) **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $318.80
A 45669	VERMILIONECTOMY, using carbon dioxide laser excision-ablation (Anaes. 17709 = 5B + 4T) *(See para T8.51 of explanatory notes to this Category)* **Fee:** $239.40 **Benefit:** 75% = $179.55 85% = $203.50
A 45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes. 17711 = 6B + 5T) **Fee:** $220.85 **Benefit:** 75% = $165.65 85% = $187.75
A 45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes. 17711 = 6B + 5T) **Fee:** $336.80 **Benefit:** 75% = $252.60 85% = $286.80
A 45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes. 17708 = 6B + 2T) **Fee:** $220.85 **Benefit:** 75% = $165.65 85% = $187.75
A 45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes. 17714 = 7B + 7T) **Fee:** $358.90 **Benefit:** 75% = $269.20 85% = $308.90
A 45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture (Anaes. 17713 = 5B + 8T) **Fee:** $369.95 **Benefit:** 75% = $277.50 85% = $319.95
	SUBGROUP 14 - HAND SURGERY
A 46500	GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17706 = 3B + 3T) (Assist.) **Fee:** $193.30 **Benefit:** 75% = $145.00 85% = $164.35
A 46501	GANGLION OF VOLAR WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $241.65 **Benefit:** 75% = $181.25 85% = $205.45
A 46502	RECURRENT GANGLION OF DORSAL WRIST JOINT, excision of, not being a service associated with a service to which item 30106 or 30107 applies (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $222.35 **Benefit:** 75% = $166.80 85% = $189.00
	SUBGROUP 15 - ORTHOPAEDIC
A 47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes. 17707 = 3B + 4T) (Assist.) **Fee:** $207.35 **Benefit:** 75% = $155.55 85% = $176.25
A 47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $207.35 **Benefit:** 75% = $155.55 85% = $176.25
A 47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $276.50 **Benefit:** 75% = $207.40 85% = $235.05

A 47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $276.50 **Benefit:** 75% = $207.40 85% = $235.05
† 47920	BONE GROWTH STIMULATOR, insertion of (Anaes. 17708 = 4B + 4T) (Assist.) **Fee:** $279.60 **Benefit:** 75% = $209.70 85% = $237.70
A 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 (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $193.55 **Benefit:** 75% = $145.20 85% = $164.55
A 47936	EXOSTOSIS OF LARGE BONE, excision of (Anaes. 17706 = 4B + 2T) (Assist.) **Fee:** $186.65 **Benefit:** 75% = $140.00 85% = $158.70
† 47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $267.95 **Benefit:** 75% = $201.00 85% = $227.80
A 48609	SCOLIOSIS or KYPHOSIS, spinal fusion for, using Harrington or other nonsegmental fixation (Anaes. 17732 = 13B + 19T) (Assist.) **Fee:** $1,209.75 **Benefit:** 75% = $907.35 85% =$1,159.75
A 49366	HIP, arthroscopic surgery of (Anaes. 17710 = 4B + 6T) (Assist.) **Fee:** $449.35 **Benefit:** 75% = $337.05 85% = $399.35
A 50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes. 17716 = 3B + 13T) (Assist.) **Fee:** $676.95 **Benefit:** 75% = $507.75 85% = $626.95
A 50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes. 17710 = 3B + 7T) (Assist.) **Fee:** $412.30 **Benefit:** 75% = $309.25 85% = $362.30
	GROUP T9 - ASSISTANCE AT OPERATIONS
‡ 51300	**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.* Assistance at any operation identified by the word "Assist." for which the fee does not exceed $410.00 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $410.00 **Fee:** $63.35 **Benefit:** 75% = $47.55 85% = $53.85
‡ 51303	Assistance at any operation identified by the word "Assist." for which the fee exceeds $410.00 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds $410.00. **Derived Fee:** one fifth of the established fee for the operation or combination of operations
† 51315	Assistance at cataract and intraocular lens surgery covered by items 42698,42701, 42702, 42704, 42707, 42710 when performed in association with services covered by items 42551 to 42569, 42653, 42656, 42746, 42749, 42752, 42776 or 42779 **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
† 51318	Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage **Fee:** $132.00 **Benefit:** 75% = $99.00 85% = $112.20

	GROUP O2 - ASSISTANCE AT OPERATION
‡ 51800	Assistance by an approved dental practitioner at any operation under an item in groups O3 to O9 identified by the word "Assist." for which the fee does not exceed $410.00 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed $410.00 *(See para OC. of explanatory notes to this Category)* **Fee:** $63.35 **Benefit:** 75% = $47.55 85% = $53.85
‡ 51803	Assistance by an approved dental practitioner at any operation under an item in groups O3 to O9 identified by the word "Assist." for which the fee exceeds $410.00 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds $410.00 *(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
@ 52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes. 17707 = 4B + 3T) (Assist.) **Fee:** $203.20 **Benefit:** 75% = $152.40 85% = $172.75
† 52034	PREMALIGNANT LESIONS of the oral mucous, treatment by liquid nitrogen cryotherapy **Fee:** $31.45 **Benefit:** 75% = $23.60 85% = $26.75
† 52106	ARCH BARS, 1 or more, which were inserted for dental fixation purposes to the maxilla or mandible, removal of, requiring general anaesthesia where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes. 17706 = 4B + 2T) **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00
‡+ 52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes. 17722 = 10B + 12T) (Assist.) **Fee:** $607.40 **Benefit:** 75% = $455.55 85% = $557.40
	GROUP O4 - PLASTIC & RECONSTRUCTIVE
† 52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes. 17714 = 7B + 7T) (Assist.) **Fee:** $785.00 **Benefit:** 75% = $588.75 85% = $735.00
	GROUP O5 - PREPROSTHETIC
† 52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes. 17711 = 6B + 5T) **Fee:** $369.95 **Benefit:** 75% = $277.50 85% = $319.95
† 52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes. 17706 = 4B + 2T) **Fee:** $136.95 **Benefit:** 75% = $102.75 85% = $116.45
	GROUP O7 - EAR, NOSE & THROAT
† 53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes. 17708 = 5B + 3T) (Assist.) **Fee:** $354.85 **Benefit:** 75% = $266.15 85% = $304.85
	GROUP O8 - TEMPOROMANDIBULAR JOINT
+ 53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $300.00 **Benefit:** 75% = $225.00 85% = $255.00

+ 53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $480.00 **Benefit:** 75% = $360.00 85% = $430.00
+ 53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $710.00 **Benefit:** 75% = $532.50 85% = $660.00
	GROUP O9 - TREATMENT OF FRACTURES
† 53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies **Fee:** $31.50 **Benefit:** 75% = $23.65 85% = $26.80
† 53459	NASAL BONES, treatment of fracture of, by reduction (Anaes. 17707 = 5B + 2T) **Fee:** $172.85 **Benefit:** 75% = $129.65 85% = $146.95
† 53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $352.60 **Benefit:** 75% = $264.45 85% = $302.60

	GROUP I3 - DIAGNOSTIC RADIOLOGY
	SUBGROUP 15 - FLUOROSCOPIC EXAMINATION AND REPORT
‡ 60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes. 17707 = 5B + 2T) **Fee:** $44.95 **Benefit:** 75% = $33.75 85% = $38.25
‡ 60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination)(R) **Fee:** $30.85 **Benefit:** 75% = $23.15 85% = $26.25

	GROUP P1 - HAEMATOLOGY
‡ 65005	Examination of blood film, or 5 part differential cell count, or both 5 part differential cell count and examination of blood film, including (if performed): (a) a service described in item 65027; and (b) any of the following services: (i) examination of blood film by special stains to demonstrate Heinz bodies, parasites or iron; (ii) examination of a blood film with alpha-naphthyl acetate esterase, chloroacetate esterase, neutrophil alkaline phosphatase, nitroblue tetrazolium, periodic acid Schiff or Sudan Black stains or acid elution stains **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75
+ 65013	Bone marrow trephine biopsy - histopathological examination of sections of bone marrow, including (if performed): (a) examination of aspirated material; and (b) special stains or immunochemical techniques (if any); and (c) a service described in item 65001, 65003, 65005, 65007 or 65015 **Fee:** $163.70 **Benefit:** 75% = $122.80 85% = $139.15
† 65052	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) including any service described in item 65005 (if performed) **Fee:** $10.25 **Benefit:** 75% = $7.70 85% = $8.75
† 65053	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell surface antigens using flow cytometric methods including any service described in item 65007 or 65052 (if performed) **Fee:** $34.00 **Benefit:** 75% = $25.50 85% = $28.90
	GROUP P2 - CHEMICAL
+ 66295	Personal performance by a recognised pathologist of 1 or more of the following: (a) growth hormone suppression by glucose loading; (b) growth hormone stimulation by exercise; (c) dexamethasone suppression test; (d) L-dopa stimulation of growth hormone **Fee:** $50.00 **Benefit:** 75% = $37.50 85% = $42.50
+ 66297	Personal performance by a recognised pathologist of 1 of the following: (a) gonadotrophin releasing hormone stimulation test; (b) synacthen stimulation test; (c) glucagon stimulation test with C-peptide measurement; (d) pentagastrin stimulation of thyrocalcitonin release; (e) secretin stimulation of gastrin release; (f) insulin hypoglycaemia; (g) arginine infusion **Fee:** $80.00 **Benefit:** 75% = $60.00 85% = $68.00
+ 66299	Personal performance by a recognised pathologist of 2 or more tests described in item 66297 **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00
† 66322	Quantitation of glycosylated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - each test to a maximum of 6 tests in a 12 month period which includes the whole pregnancy, including a service in item 66319 (if performed) **Fee:** $16.60 **Benefit:** 75% = $12.45 85% = $14.15
‡ 66327	TSH quantitation **Fee:** $31.55 **Benefit:** 75% = $23.70 85% = $26.85
‡ 66405	Quantitation of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, cyclic AMP, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IgF1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (antidiuretic hormone) - 1 test **Fee:** $31.55 **Benefit:** 75% = $23.70 85% = $26.85

†	TSH quantitation described in item 66327 and 1 test described in item 66405 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)
66427	**Fee:** $42.55 **Benefit:** 75% = $31.95 85% = $36.20
†	TSH quantitation described in item 66327 and 2 tests described in item 66405 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)
66428	**Fee:** $53.55 **Benefit:** 75% = $40.20 85% = $45.55
†	TSH quantitation described in item 66327 and 3 tests described in item 66405 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)
66429	**Fee:** $64.55 **Benefit:** 75% = $48.45 85% = $54.90
†	TSH quantitation described in item 66327 and 4 tests described in item 66405 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA) (Item is subject to rule 6)
66430	**Fee:** $75.55 **Benefit:** 75% = $56.70 85% = $64.25
†	TSH quantitation described in item 66327 and 5 tests described in item 66405 (This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs 6 or more tests specified on the request form) (Item is subject to rule 6)
66431	**Fee:** $86.55 **Benefit:** 75% = $64.95 85% = $73.60
†	Tests described in items 66327 and item 66405, if rendered under a request mentioned in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to Rule 6)
66432	**Fee:** $11.05 **Benefit:** 75% = $8.30 85% = $9.40
	GROUP P3 - MICROBIOLOGY
‡	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy) including: (a) the determination of 1 of the following: rubella immune status, specific syphilis serology or hepatitis B surface antigen; and (b) a service described in 1 or more of items 69229, 69266 to 69273, 69275 to 69278, 69280 and 69281 (if performed)
69253	**Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy) including: (a) the determination of 2 of the following: rubella immune status, specific syphilis serology or hepatitis B antigen; and (b) a service described in 1 or more of items 69229, 69266 to 69273, 69275 to 69278, 69280 and 69281 (if performed)
69255	**Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00

‡ 69257	Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness during that pregnancy) including : (a) the determination of all 3 of the following: rubella immune status, specific syphilis serology and hepatitis B surface antigen; and (b) a service described in 1 or more of items 69229, 69266 to 69273, 69275 to 69278, 69280 and 69281 (if performed) **Fee:** $34.70 **Benefit:** 75% = $26.05 85% = $29.50
‡ 69266	Investigation for acute Hepatitis A using: Hepatitis A IgM antibody test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡ 69267	Determination of immune status to Hepatitis A using: Hepatitis A IgG antibody test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡ 69268	Investigation for acute or resolving Hepatitis B, or testing of close, recent contacts of proven Hepatitis B infection, including: (a) Hepatitis B surface antigen test; and (b) Hepatitis B core antibody test; and (if performed) (c) Hepatitis B e antibody test (if the Hepatitis B surface antigen test is negative and Hepatitis B core antibody test is positive) (if performed) (Item is subject to rule 12) **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
‡ 69269	Investigation for resolution of Hepatitis B if the Hepatitis B core antibody test is positive and the Hepatitis B surface antigen test is negative, including: (a) Hepatitis B core antibody test; and (b) Hepatitis B surface antigen test; and (c) Hepatitis B surface antibody test (Item is subject to rule 12) **Fee:** $34.70 **Benefit:** 75% = $26.05 85% = $29.50
‡ 69270	Determination of immune status to Hepatitis B (post exposure) using: Hepatitis B core antibody test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡ 69271	Determination of immune status to Hepatitis B (post vaccination) using: Hepatitis B surface antibody test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡ 69272	Investigation for chronic Hepatitis B or determination of carriage of Hepatitis B antigen using: Hepatitis B surface antigen test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡ 69274	Testing for Hepatitis C using: Hepatitis C antibody test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85

‡ 69275	Investigation for acute or chronic Hepatitis D in a patient with a positive Hepatitis B surface antigen test using: Hepatitis D antibody test (Item is subject to rule 12) **Fee:** $13.90 **Benefit:** 75% = $10.45 85% = $11.85
‡ 69277	Investigation for chronic viral hepatitis, or Hepatitis B or Hepatitis C carriage, including: (a) Hepatitis B surface antigen test; and (b) Hepatitis C antibody test (Item is subject to rule 12) **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
‡ 69278	Investigation for chronic viral hepatitis, or Hepatitis B or Hepatitis C carriage, where the Hepatitis B surface antigen test is positive, including: (a) Hepatitis C antibody test; and (b) Hepatitis B surface antigen test; and (c) Hepatitis B e antigen test (Item is subject to rule 12) **Fee:** $34.70 **Benefit:** 75% = $26.05 85% = $29.50
‡ 69279	Investigation for acute Hepatitis A, Hepatitis B, Hepatitis C and Hepatitis D in a patient with a currently elevated transaminase level, including: (a) Hepatitis A IgM antibody test; and (b) Hepatitis C antibody test; and (c) Hepatitis B surface antigen test; and (d) Hepatitis B core antibody test; and (e) Hepatitis B e antibody test (if Hepatitis B surface antigen test is negative and Hepatitis B core antibody test is positive) (if performed); and (f) Hepatitis D antibody test (if Hepatitis B surface antigen test is positive) (if performed) (Item is subject to rule 12) **Fee:** $44.70 **Benefit:** 75% = $33.55 85% = $38.00
†	Determination of immune status to Hepatitis B and testing for Hepatitis C, including: (a) Hepatitis C antibody test; and (b) Hepatitis B core antibody test or Hepatitis B surface antibody test (Item is subject to rule 12) 69280 **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
†	Investigation for acute Hepatitis A and Hepatitis C in a patient with a currently elevated transaminase level, including: (a) Hepatitis A IgM antibody test; and (b) Hepatitis C antibody test (Item is subject to rule 12) 69283 **Fee:** $24.70 **Benefit:** 75% = $18.55 85% = $21.00
	GROUP P5 - TISSUE PATHOLOGY
†	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 14) 72813 **Fee:** $79.00 **Benefit:** 75% = $59.25 85% = $67.15
†	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 14) 72816 **Fee:** $84.50 **Benefit:** 75% = $63.40 85% = $71.85

†	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 or more separately identified specimens
72817	(Item is subject to rule 14) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
†	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen
72823	(Item is subject to rule 14) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
†	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens
72824	(Item is subject to rule 14) **Fee:** $96.00 **Benefit:** 75% = $72.00 85% = $81.60
†	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens
72825	(Item is subject to rule 14) **Fee:** $102.00 **Benefit:** 75% = $76.50 85% = $86.70
†	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens
72830	(Item is subject to rule 14) **Fee:** $105.00 **Benefit:** 75% = $78.75 85% = $89.25
†	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens
72836	(Item is subject to rule 14) **Fee:** $115.00 **Benefit:** 75% = $86.25 85% = $97.75
†	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies
72846	(Item is subject to rule 14) **Fee:** $30.00 **Benefit:** 75% = $22.50 85% = $25.50
†	Immunohistochemical examination of biopsy material by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies
72847	(Item is subject to rule 14) **Fee:** $40.00 **Benefit:** 75% = $30.00 85% = $34.00
†	Electron microscopic examination of biopsy material - 1 separately identified specimen
72851	(Item is subject to rule 14) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50
†	Electron microscopic examination of biopsy material - 2 or more separately identified specimens
72852	(Item is subject to rule 14) **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
†	Intraoperative frozen section diagnosis of biopsy material - 1 separately identified specimen
72855	(Item is subject to rule 14) **Fee:** $150.00 **Benefit:** 75% = $112.50 85% = $127.50

†	Intraoperative frozen section diagnosis of biopsy material - 2 or more separately identified specimens (Item is subject to rule 14)
72856	**Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00
	GROUP P6 - CYTOLOGY
+	Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids 1 or more tests
73045	**Fee:** $45.00 **Benefit:** 75% = $33.75 85% = $38.25
+	Cytology of a series of 3 sputum or urine specimens for malignant cells
73047	**Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
+	Cytology material obtained directly from a patient by fine needle aspiration of solid tissue or tissues
73049	**Fee:** $65.00 **Benefit:** 75% = $48.75 85% = $55.25
+	Cytology material obtained directly from a patient by fine needle aspiration of solid tissue or tissues if: (a) the aspiration is performed by a recognised pathologist; or (b) a recognised pathologist attends the aspiration and performs cytological examination during the attendance
73051	**Fee:** $163.85 **Benefit:** 75% = $122.90 85% = $139.30
‡	Cytology of smears from cervix: (a) for detection of pre-cancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia; or (b) due to an unsatisfactory smear taken in the circumstances defined in para (a) above; or (c) if there is inadequate information provided to use item 73055 each examination *(See para PQ. of explanatory notes to this Category)*
73053	**Fee:** $17.80 **Benefit:** 75% = $13.35 85% = $15.15
	GROUP P10 - PATIENT EPISODE INITIATION
‡	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 from a person who is an in-patient of a hospital other than a recognised hospital
73903	**Fee:** $14.15 **Benefit:** 75% = $10.65 85% = $12.05
‡	Initiation of a patient episode that consists only of 1 or more services described in items 72813, 72816, 72817, 72823, 72824, 72825, 72830 and 72836 from a person who is not an in-patient of a private hospital and not a patient of a recognised hospital
73905	**Fee:** $7.85 **Benefit:** 75% = $5.90 85% = $6.70
†	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903 or 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in the place where the person was residing
73910	**Fee:** $10.00 **Benefit:** 75% = $7.50 85% = $8.50
†	Initiation of a patient episode by collection of a specimen for a service (other than a service described in item 73901, 73903 or 73905 or in Group P9) if the specimen is collected by an approved pathology practitioner or an employee of an approved pathology authority from a person in a nursing home or institution
73912	**Fee:** $10.00 **Benefit:** 75% = $7.50 85% = $8.50

DIAGNOSTIC IMAGING FEES AS 19 FEB 1997

*** Indicate fee change as at 19 February 1997**

Item No.	Medicare Benefit Fee $	75%	Schedule 85% - $50 max Gap
55028	98.75	74.10	83.95
55029	34.25	25.70	29.15
55030	98.75	74.10	83.95
55031	34.25	25.70	29.15
55032	98.75	74.10	83.95
55033	34.25	25.70	29.15
55034	98.75	74.10	83.95
55035	34.25	25.70	29.15
55036	98.75	74.10	83.95
55037	34.25	25.70	29.15
55038	98.75	74.10	83.95
55039	34.25	25.70	29.15
55040	98.75	74.10	83.95
55041	34.25	25.70	29.15
55042	98.75	74.10	83.95
55043	34.25	25.70	29.15
55044	98.75	74.10	83.95
55045	34.25	25.70	29.15
55048	99.15	74.40	84.30
55049	34.25	25.70	29.15
55050	99.15	74.40	84.30
55051	34.25	25.70	29.15
55052	98.75	74.10	83.95
55053	34.25	25.70	29.15
55054	98.75	74.10	83.95
55055	59.80	44.85	50.85
55056	5.20	3.90	4.45
55057	5.20	3.90	4.45
55058	26.95	20.25	22.95
55102	162.05	121.55	137.75
55105	91.70	68.80	77.95
55112*	254.65	191.00	216.50
55118*	254.10	190.60	216.00
55130*	367.95	276.00	317.95
55201	170.60	127.95	145.05
55204*	300.70	225.55	255.60
55207	170.60	127.95	145.05
55210	170.60	127.95	145.05
55225*	205.00	153.75	174.25
55231*	341.05	255.80	291.05
55234	198.30	148.75	168.60
55237*	219.95	165.00	187.00
55300	98.75	74.10	83.95
55303	98.75	74.10	83.95
56001	195.15	146.40	165.90
56007*	249.20	186.90	211.85
56010*	282.35	211.80	240.00
56013*	282.35	211.80	240.00
56016*	336.25	252.20	286.25
56019*	413.10	309.85	363.10
56022*	223.70	167.80	190.15
56028*	332.95	249.75	283.05
56101*	230.05	172.55	195.55
56107*	339.25	254.45	289.25
56210*	242.15	181.65	205.85
56216*	350.90	263.20	300.90
56219*	325.80	244.35	276.95
56301*	295.55	221.70	251.25
56307*	399.80	299.85	349.80
56401*	250.75	188.10	213.15
56407*	358.75	269.10	308.75
56409*	250.75	188.10	213.15
56412*	358.75	269.10	308.75
56501*	381.80	286.35	331.80
56507*	481.80	361.35	431.80
56619*	221.60	166.20	188.40
56625*	330.85	248.15	281.25
56801*	461.15	345.90	411.15
56807*	561.15	420.90	511.15
57001*	461.25	345.95	411.25
57007*	561.25	420.95	511.25
57201	153.45	115.10	130.45
57341*	478.45	358.85	428.45
57350*	522.20	391.65	472.20
57506	30.85	23.15	26.25
57509	41.15	30.90	35.00
57512	41.90	31.45	35.65
57515	55.90	41.95	47.55
57518	33.70	25.30	28.65
57521	44.95	33.75	38.25
57524	51.10	38.35	43.45
57527	68.10	51.10	57.90
57700	41.90	31.45	35.65
57703	55.90	41.95	47.55
57706	33.70	25.30	28.65
57709	44.95	33.75	38.25
57712	48.80	36.60	41.50
57715	63.15	47.40	53.70
57721	102.75	77.10	87.35
57900	66.80	50.10	56.80
57903	48.80	36.60	41.50
57906	66.80	50.10	56.80
57909	66.80	50.10	56.80
57912	48.80	36.60	41.50
57915	48.80	36.60	41.50
57918	48.80	36.60	41.50
57921	48.80	36.60	41.50
57924	48.80	36.60	41.50
57927	51.40	38.55	43.70
57930	34.05	25.55	28.95
57933	80.95	60.75	68.85
57936	49.00	36.75	41.65
57939	66.80	50.10	56.80
57942	51.40	38.55	43.70
57945	44.95	33.75	38.25
58100	69.55	52.20	59.15

Item No.	Schedule Fee $	Medicare Benefit 75%	85% - $50 max Gap
58103	57.15	42.90	48.60
58106	79.70	59.80	67.75
58109	48.60	36.45	41.35
58112	100.70	75.55	85.60
58115	137.65	103.25	117.05
58300	41.50	31.15	35.30
58306	92.55	69.45	78.70
58500	36.60	27.45	31.15
58503	48.80	36.60	41.50
58506	62.95	47.25	53.55
58509	41.15	30.90	35.00
58521	44.95	33.75	38.25
58524	58.45	43.85	49.70
58527	71.95	54.00	61.20
58700	48.80	36.60	41.50
58706	128.25	96.20	109.05
58709	159.70	119.80	135.75
58715	102.75	77.10	87.35
58718	68.10	51.10	57.90
58721	80.95	60.75	68.85
58900	36.60	27.45	31.15
58903	48.80	36.60	41.50
58906	69.40	52.05	59.00
58909	95.10	71.35	80.85
58912	113.10	84.85	96.15
58915	80.95	60.75	68.85
58918	95.10	71.35	80.85
58921	113.10	84.85	96.15
58924	80.95	60.75	68.85
58927	78.40	58.80	66.65
58933	92.55	69.45	78.70
58936	154.20	115.65	131.10
58939	142.90	107.20	121.50
59300	80.95	60.75	68.85
59303	48.80	36.60	41.50
59306	93.35	70.05	79.35
59309	186.75	140.10	158.75
59503	92.55	69.45	78.70
59700	71.95	54.00	61.20
59703	48.80	36.60	41.50
59712	69.40	52.05	59.00
59718	102.75	77.10	87.35
59724	123.35	92.55	104.85
59727*	205.70	154.30	174.85
59730*	277.95	208.50	236.30
59733	69.40	52.05	59.00
59736	69.40	52.05	59.00
59745	43.70	32.80	37.15
59748	51.40	38.55	43.70
59751	89.95	67.50	76.50
59754	68.10	51.10	57.90
59760	119.20	89.40	101.35
59763	138.60	103.95	117.85
59900	86.60	64.95	73.65
59903	119.20	89.40	101.35
59906	119.20	89.40	101.35
59912*	317.55	238.20	269.95
59915	80.95	60.75	68.85
59918	102.75	77.10	87.35
59921	102.75	77.10	87.35
59924	102.75	77.10	87.35
59970	156.85	117.65	133.35
60000*	525.50	394.15	475.50
60003*	770.65	578.00	720.65
60006*	1095.85	821.90	1045.85
60009*	1282.45	961.85	1232.45
60012*	525.50	394.15	475.50
60015*	770.65	578.00	720.65
60018*	1095.85	821.90	1045.85
60021*	1282.45	961.85	1232.45
60024*	525.50	394.15	475.50
60027*	770.65	578.00	720.65
60030*	1095.85	821.90	1045.85
60033*	1282.45	961.85	1232.45
60036*	525.50	394.15	475.50
60039*	770.65	578.00	720.65
60042*	1095.85	821.90	1045.85
60045*	1282.45	961.85	1232.45
60048*	525.50	394.15	475.50
60051*	770.65	578.00	720.65
60054*	1095.85	821.90	1045.85
60057*	1282.45	961.85	1232.45
60060*	525.50	394.15	475.50
60063*	770.65	578.00	720.65
60066*	1095.85	821.90	1045.85
60069*	1282.45	961.85	1232.45
60072	44.80	33.60	38.10
60075	89.60	67.20	76.20
60078	134.35	100.80	114.20
60100	62.95	47.25	53.55
60500	44.95	33.75	38.25
60503	30.85	23.15	26.25
60506	66.05	49.55	56.15
60509	102.35	76.80	87.00
60700	5.20	3.90	4.45
60903	132.75	99.60	112.85
60909	41.15	30.90	35.00
60915	73.10	54.85	62.15
60918	54.50	40.90	46.35
60927	45.00	33.75	38.25
60930	62.95	47.25	53.55
60933	50.10	37.60	42.60
60936	50.20	37.65	42.70
60939	37.65	28.25	32.05
60942	70.65	53.00	60.10
60945	62.95	47.25	53.55

Item No.	Schedule Fee $	Medicare Benefit 75%	85% - $50 max Gap
60948	41.15	30.90	35.00
60957	123.35	92.55	104.85
60966	21.35	16.05	18.15
60969	56.10	42.10	47.70
60972	123.35	92.55	104.85
60981	123.35	92.55	104.85
61109*	268.05	201.05	227.85
61302*	379.00	284.25	329.00
61303*	489.00	366.75	439.00
61306*	599.25	449.45	549.25
61307*	729.25	546.95	679.25
61310*	310.15	232.65	263.65
61313*	261.00	195.75	221.85
61314*	359.50	269.65	309.50
61316*	326.65	245.00	277.70
61317*	420.60	315.45	370.60
61320	193.30	145.00	164.35
61328	183.50	137.65	156.00
61340*	213.65	160.25	181.65
61348*	376.80	282.60	326.80
61352*	219.00	164.25	186.15
61353*	326.40	244.80	277.45
61356*	331.65	248.75	281.95
61360*	344.50	258.40	294.50
61361*	394.50	295.90	344.50
61364*	419.60	314.70	369.60
61368	188.40	141.30	160.15
61372	188.40	141.30	160.15
61373*	413.50	310.15	363.50
61376	121.10	90.85	102.95
61381*	509.25	381.95	459.25
61383*	552.00	414.00	502.00
61384*	609.80	457.35	559.80
61386*	280.75	210.60	238.65
61387*	385.05	288.80	335.05
61389*	312.95	234.75	266.05
61390*	346.20	259.65	296.20
61393*	521.00	390.75	471.00
61397*	208.45	156.35	177.20
61401	137.00	102.75	116.45
61402*	510.90	383.20	460.90
61405*	292.20	219.15	248.40
61409*	737.60	553.20	687.60
61413	190.80	143.10	162.20
61417	100.30	75.25	85.30
61421*	409.50	307.15	359.50
61425*	513.50	385.15	463.50
61426*	468.50	351.40	418.50
61429*	458.50	343.90	408.50
61430*	568.50	426.40	518.50
61433*	419.60	314.70	369.60
61434*	519.60	389.70	469.60
61437*	458.30	343.75	408.30
61438*	568.30	426.25	518.30
61441*	413.50	310.15	363.50
61446*	285.05	213.80	242.30
61449*	391.10	293.35	341.10
61450*	335.70	251.80	285.70
61453*	446.20	334.65	396.20
61454*	293.90	220.45	249.85
61457*	397.30	298.00	347.30
61458*	335.15	251.40	285.15
61461*	445.70	334.30	395.70
61465*	224.25	168.20	190.65
61469*	293.90	220.45	249.85
61473	150.00	112.50	127.50
61480*	326.65	245.00	277.70
61484*	743.80	557.85	693.80
61485*	843.80	632.85	793.80
61495	188.40	141.30	160.15
61499*	213.65	160.25	181.65
61503	5.20	3.90	4.45