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COMMONWEALTH OF AUSTRALIA

Diagnostics & Technology Branch (MDP 107)
GPO Box 9848
Canberra ACT 2601
Telephone: (02) 6289 8657
Fax: (02) 6289 8509

Commonwealth Department of
Health and
Family Services

Mr Nick Brown
Manager
Medicare Assessing
Health Insurance Commission
PO Box 1001
TUGGERNONG ACT 2901

Dear Mr/NICK Brown

I am writing to confirm that four new items are to be included in the 1997-98 Pathology Services Table of the Medicare Benefits Schedule, and expected to take effect by 1 July 1998.

As you are aware, based on recommendations made in the Australian Health Technology Advisory Committee (AHTAC) report on Nucleic Acid Amplification (NAA) Technology, the Pathology Services Table Committee has recommended the following new tests for inclusion on the Pathology Services Table:

1. **viral load testing for HIV/AIDS**

69259 Quantitation of HIV viral RNA load in plasma, serum or cerebrospinal fluid in the monitoring of a HIV sero-positive patient, who is not on antiretroviral therapy. One or more assays on one or more specimens in any one episode to a maximum of 6 episodes in a 12 month period.

69260 Quantitation of HIV viral RNA load in plasma, serum or cerebrospinal fluid in the monitoring of antiretroviral therapy in a HIV sero-positive patient. One or more assays on one or more specimens in any one episode to a maximum of 6 episodes in a 12 month period.

Rule
For items 69259 and 69260, no more than a maximum of 6 episodes for either item 69259 or item 69260 or any combination for both items, can be claimed in a 12 month period.

Fee
Schedule fee for item 69259 and 69260 is $150.00

2. viral load testing for hepatitis C

69284 Detection of Hepatitis C viral RNA if at least one of the following criteria is satisfied:

a) the patient is Hepatitis C sero-positive and has normal liver function tests on two occasions six months apart;

b) the patient's serological status is uncertain after testing;

c) the test is performed for the purpose of :

(i) determining the Hepatitis C status in immunosuppressed in an immunocompromised patient; or

(ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient.

Not exceeding 1 episode in a 12 month period.

Rule

For item 69284: "Hepatitis C sero-positive" means that two different assays of Hepatitis C antibodies are positive;
"serological status is uncertain" means any result where two different assays of Hepatitis C antibodies are inconclusive."

Fee

Schedule fee is $64.00

3. nucleic acid amplification testing for Haemochromatosis

66435 Detection of the C282Y genetic mutation for haemochromatosis where:

a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or

b) the patient has a first degree relative with haemochromatosis or with homozygosity for the C282Y genetic mutation.

Not exceeding 1 episode in a 3 year period.

Rule

For item 66435: "elevated serum ferritin" means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level."

Fee

Schedule fee is $36.00

As discussed at our meeting on 22 May, some consumers have expressed concerns regarding patient confidentiality, mainly relating to billing of the HIV viral load test. In an attempt to address these concerns, laboratories undertaking the testing will be asked to use the appropriate Medicare number for the test along with the code "VLT" rather than spelling out the entire item descriptor. This should ensure that any invoice sent to the patient does not specifically identify the viral load test as a test for HIV/AIDS.

There will be no need for any specific coding in relation to either of the three tests except for restrictions outlined in the item descriptors and the rules.

If you have any further queries, please do not hesitate to contact me on 62898657.

Yours sincerely

Jillian Barr
Director
Pathology Section

3 June 1998

COMMONWEALTH OF AUSTRALIA
Health Benefits Division
Canberra ACT 2606

Commonwealth Department of
Health and Family Services

NEW ARRANGEMENTS FOR FUNDING MAGNETIC RESONANCE IMAGING (MRI) SERVICES UNDER MEDICARE BENEFITS SCHEDULE FROM 1 SEPTEMBER 1998

New arrangements for funding of Magnetic Resonance Imaging (MRI) services will come into effect from 1 September 1998. At this time, Medicare Benefits will be introduced for a range of MRI services.

The new arrangements have been developed in response to the recommendations of the Australian Health Technology Advisory Committee's (AHTAC) "Review of Magnetic Resonance Imaging". They expand Government funding to a range of MRI services provided in both the public and private sectors. Previously, Government funding was limited to 18 public hospital units via Health Program Grants.

To assist you in understanding the new arrangements, a booklet entitled *Magnetic Resonance Imaging (MRI) Medicare Benefits Schedule Items As At 1 September 1998* is enclosed.

The new arrangements contain a series of measures to promote quality, appropriate and cost effective use and practice in line with AHTAC's recommendations. An overview of the key features of the arrangements is provided below.

MBS Itemisation

A range of Medicare Benefits Schedule (MBS) items for MRI applications has been developed to reflect AHTAC's findings on the evidence of the clinical role and value of MRI. Items are for specific clinical indications with numbers of scans specified in a 12-month period consistent with clinical practice for particular conditions.

Referral Arrangements

MRI will continue to be a service requiring a referral by a specialist or consultant physician. Requests must specify in writing the clinical indications for the scan. Oral and maxillofacial surgeons are able to request scans of the temporomandibular joint.

Provider Eligibility Requirements

Providers need to satisfy a number of requirements in order to be eligible to provide MRI services under the Medicare Benefits arrangements:

- providers must be specialists in diagnostic radiology, participating in the Royal Australasian College of Radiologist's Quality and Accreditation Program;

- services must be performed under the professional supervision of an eligible MRI provider
  - this measure to promote quality standard of service has been developed and endorsed by the Royal Australasian College of Radiologists
  - a full definition of professional supervision is provided in the explanatory notes in the booklet;

- services must be provided on eligible equipment
  - this is equipment that is in a hospital or medical practice that offers a range of diagnostic imaging procedures
  - as a minimum, X-ray, ultrasound and computerised tomography (CT) procedures are needed to meet this requirement
  - this requirement is consistent with AHTAC's recommendation and is to facilitate selection of the most suitable imaging modality for a particular condition;

- eligible equipment must have been installed in a medical practice or hospital before 7.30 pm on 12 May 1998, Eastern Standard Time; or although uninstalled, have been purchased or leased before that time on that day under a contract, in writing, that did not contain an option to cancel the contract
  - this is in recognition of AHTAC's findings that there is currently an overcapacity of MRI in Australia;

- upgrading and replacement of eligible equipment is permitted to promote quality service provision
  - any services provided on the original equipment would then cease to be eligible to attract Medicare Benefits.

MRI providers wishing to be eligible for Medicare payment purposes are required to satisfy the Health Insurance Commission of eligibility and lodge a statutory declaration.

Detailed information on eligibility requirements has been sent to diagnostic radiologists. Radiologists not receiving this information should contact the Health Insurance Commission on 132 150.

Adjustment and Relocation Scheme

As part of the new arrangements, an Adjustment and Relocation Scheme is being developed to assist in sectoral adjustment to the new arrangements and to encourage the relocation of MRI services to under serviced areas.

Medicare Schedule Fee

The schedule fee for MRI is $475. This fee contains a component towards capital costs.

MRI-related Anaesthesia Services

Access to MBS item 18013 has been extended to cover cases where anaesthesia is required in conjunction with MRI items.

New Clinical Applications of MRI

New applications of MRI beyond those included in the Medicare Benefits Schedule, will require assessment by the Medicare Services Advisory Committee (MSAC). The MSAC Secretariat can be contacted on (02) 6289 4488 or Email msac.secretariat@health.gov.au

Review

These arrangements will be reviewed within 18 months. During this time, data will be collected on MRI clinical use and delivery and some support will be provided for research into the clinical role and value of MRI and other diagnostic imaging modalities.

Further Information

Further information about the new arrangements may be obtained from:

- The Health Information Line (Freecall) – 1800 020 613;
- The Health Insurance Commission's (HIC) Provider Liaison Area – 132 150;
- The Department of Health and Family Services (DHFS) by Internet e-mail mri@health.gov.au

A list of MRI items is also recorded in an ASCII text file on the Department of Health and Family Services' Website (http://www health.gov.au). To access this file select "HFS Publications" from the main page, go to "Health Economics/Insurance/Medicare" and then select "MBS ASCIItext file [MONTH]".

These items will appear in the next edition of the Medicare Benefits Schedule.

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

MAGNETIC RESONANCE IMAGING (MRI)

MEDICARE BENEFITS SCHEDULE ITEMS AS AT 1 SEPTEMBER 1998

EXPLANATORY NOTES

DIL MAGNETIC RESONANCE IMAGING

DIL.1 General

New arrangements for the payment of Medicare benefits for Magnetic Resonance Imaging (MRI) come into effect from 1 September 1998. These changes are in response to recommendations made by the Australian Health Technology Advisory Committee (AHTAC) 'Review of magnetic resonance imaging'. The new arrangements include a detailed itemisation and a number of eligibility criteria relating to MRI provision.

DIL.2 Itemisation

A series of items, Group I5, has been introduced for clinical applications of MRI, where AHTAC found evidence that MRI has a proven clinical role and is superior or complementary to other imaging modalities.

MRI items 63000 to 63946 are divided into subgroups defined according to the area of the body to be scanned, (ie head, spine, musculoskeletal system, cardiovascular system or body) and whether the scan is for the exclusion, further investigation or monitoring of a clinical condition. Subgroups are then divided into individual items, with each item being for a specific clinical indication.

Requests

MRI services can only be requested by a specialist or consultant physician. A referral must be in writing and identify the clinical indications for the service.

A MRI or Magnetic Resonance Angiography (MRA) service may be claimed for one of the three following purposes:

- *Exclusion of a condition* – where MRI or Magnetic Resonance Angiography (if performed) is used as the initial imaging modality for diagnosis;

- *Further investigation of a condition*– where MRI or MRA (if performed) is used as the secondary imaging modality when the diagnosis is uncertain or to assess the extent or severity of the condition;

- *Monitoring of a condition* – where MRI or MRA (if performed) is used following confirmed diagnosis to assess progress of a condition following treatment.

For the 'further investigation of' or 'monitoring of' purposes the initial imaging modality could have been MRI or any other diagnostic imaging modality.

DIL.2 Number of eligible services

Items have been placed in subgroups with limits on the number of services eligible for a Medicare benefit as follows:

- Subgroups 1, 2, 3, 4, 9, 10, 11, 12, 13, 14, 17, 18, 19, 22, 25, 27, 28 and 29, only one service for each subgroup can be claimed in a 12 month period;

- Subgroups 5, 6, 21, 23 and 24 only two services for each subgroup can be claimed in a 12 month period; and

- Subgroups 7, 8, 15, 16, 20, 26 and 30 which do not have a restriction on the number of eligible services.

DIL.3 Eligible services

Group I5 items, apply only to an MRI or MRA service performed:

(a) on referral by a recognised specialist or consultant physician, where the request for the scan specifically identifies in writing the clinical indication for the scan;
(b) under the professional supervision of an eligible provider; and
(c) with eligible equipment.

DIL.4 Specialist or consultant physician

Specialist or consultant physician means a medical practitioner recognised for the purposes of the Health Insurance Act 1973 as a specialist or consultant physician in a particular specialty.

DIL.5 Professional supervision

Group I5 items must be performed as follows:

(a) under the professional supervision of an eligible provider who is available to monitor and influence the conduct and diagnostic quality of the examination, including, if necessary, by personal attendance on the patient; or
(b) if the above paragraph is not complied with
  - in an emergency; or
  - because of medical necessity - in a remote or rural location.

DIL.6 Eligible providers

In Group I5, an eligible provider is a specialist in diagnostic radiology who satisfies the Health Insurance Commission (HIC) that:
(a) he or she is a participant in the Royal Australasian College of Radiologists' Quality and Accreditation Program; and
(b) the equipment he or she proposes to use for providing services of the kind mentioned in Group I5 is eligible equipment.

DIL.12 New Applications of MRI

New clinical applications of MRI not listed in this Schedule will require consideration by the Medicare Services Advisory Committee (MSAC) prior to inclusion in the Schedule. To contact MSAC write to:

The Secretary
Medicare Services Advisory Committee
MDP 107
GPO Box 9848
Canberra ACT 2601
Email msac.secretariat@health.gov.au
Fax: 61-2-6289 8799

This booklet provides information on the arrangements for the payment of Medicare benefits for Magnetic Resonance Imaging services. These arrangements operate under the Health Insurance Act 1973 (as amended). However, at the time of printing, the relevant legislation giving authority for the changes included in this advice may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This booklet is not a legal document and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

	18 GROUP T6 - ANAESTHETICS
	SUBGROUP 2 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A MEDICAL SERVICE
‡ 18013	- In connection with magnetic resonance imaging services covered by Items 63000 to 63946 (Anaes. = 7B + 7T) **Fee:** $198.80 **Benefit:** 75% = $149.10 85% = $169.00
	GROUP I5 - MAGNETIC RESONANCE IMAGING
	SUBGROUP 1 - SCAN OF HEAD - FOR THE EXCLUSION OF SPECIFIED CONDITONS
†	**NOTE: Benefits are payable for services covered in Subgroup 1 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for the exclusion of: - tumour of the brain or meninges (R)
63000	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63003	- skull base or orbital tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63006	- acoustic neuroma (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63009	- pituitary tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63012	- inflammation of brain or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63015	- toxic or metabolic or ischaemic encephalopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63018	- demyelinating disease of the brain (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63021	- congenital malformation of brain or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63024	- venous sinus thrombosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 2 - SCAN OF HEAD AND CERVICAL SPINE - FOR THE EXCLUSION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 2 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for the exclusion of: - tumour of the central nervous system or meninges (R)
63050	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

† 63053	- inflammation of the central nervous system or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63056	- demyelinating disease of the central nervous system (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63059	- congenital malformation of the central nervous system or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63062	- syrinx (congenital or acquired) (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 3 - SCAN OF HEAD - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS-
†	**NOTE: Benefits are payable for services covered by Subgroup 3 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for further investigation of:
63100	- tumour of the brain or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63103	- skull base or orbital tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63106	- acoustic neuroma (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63109	- pituitary tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63112	- inflammation of the brain or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63115	- toxic or metabolic or ischaemic encephalopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63118	- demyelinating disease of the brain (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63121	- congenital malformation of the brain or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63124	- head trauma (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63127	- epilepsy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63130	- stroke (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63133	- venous sinus thrombosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 4 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for further investigation of: - tumour of the central nervous system or meninges (R)
63150	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- inflammation of the central nervous system or meninges (R)
63153	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- demyelinating disease of the central nervous system (R)
63156	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital malformation of the central nervous system or meninges (R)
63159	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- syrinx (congenital or acquired) (R)
63162	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 5 - SCAN OF HEAD - FOR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 5 on two occasions only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for monitoring of: - acoustic neuroma (R)
63200	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- pituitary tumour (R)
63203	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- demyelinating disease of the brain (R)
63206	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital malformation of brain or meninges (R)
63209	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- head trauma (R)
63212	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- epilepsy (R)
63215	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- stroke (R)
63218	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- toxic or metabolic or ischaemic encephalopathy (R)
63221	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 6 - SCAN OF HEAD AND CERVICAL SPINE - FOR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 6 on two occasions only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for monitoring of: - demyelinating disease of the central nervous system (R) 63250 **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63253	- congenital malformation of the central nervous system or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63256	-syrinx (congenital or acquired) (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 7 - SCAN OF HEAD - FOR MONITORING OF SPECIFIED CONDITIONS
†	MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head** for monitoring of: - tumour of the brain or meninges (R) 63270 **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63273	- skull base or orbital tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63276	- inflammation of brain or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63279	- venous sinus thrombosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 8 - SCAN OF HEAD AND CERVICAL SPINE - FOR MONITORING OF SPECIFIED CONDITIONS
†	MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of head and cervical spine** for monitoring of: - tumour of the central nervous system or meninges (R) 63290 **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63293	- inflammation of the central nervous system or meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 9 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR THE EXCLUSION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 9 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for the exclusion of: - infection (R)
63300	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- tumour (R)
63303	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- demyelinating disease (R)
63306	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital malformation of the spinal cord or the cauda equina or the meninges (R)
63309	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- myelopathy (R)
63312	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- syrinx (congenital or acquired) (R)
63315	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 10 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR THE EXCLUSION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 10 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for the exclusion of: - infection (R)
63350	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- tumour (R)
63353	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- demyelinating disease (R)
63356	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital malformation of the spinal cord or the cauda equina or the meninges (R)
63359	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- myelopathy (R)
63362	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- syrinx (congenital or acquired) (R)
63365	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 11 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 11 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for further investigation of: - infection (R)
63400	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- tumour (R)
63403	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- demyelinating disease (R)
63406	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital malformation of the spinal cord or the cauda equina or the meninges (R)
63409	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- myelopathy (R)
63412	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- syrinx (congenital or acquired) (R)
63415	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- cervical radiculopathy (R)
63418	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- sciatica (R)
63421	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- spinal canal stenosis (R)
63424	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- previous spinal surgery (R)
63427	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- trauma (R)
63430	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 12 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 12 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for further investigation of: - infection (R)
63450	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- tumour (R)
63453	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

† 63456	- demyelinating disease (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63459	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63462	- myelopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63465	- syrinx (congenital or acquired) (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63468	- cervical radiculopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63471	- sciatica (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63474	- spinal canal stenosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63477	- previous spinal surgery (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63480	- trauma (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 13 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 13 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for monitoring of:
63500	- demyelinating disease (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63503	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63506	- myelopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63509	- syrinx (congenital or acquired) (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63512	- cervical radiculopathy (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63515	- sciatica (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63518	- spinal canal stenosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63521	- previous spinal surgery (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63524	- trauma (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 14 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 14 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for monitoring of: - demyelinating disease (R)
63550	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital malformation of the spinal cord or the cauda equina or the meninges (R)
63553	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- myelopathy (R)
63556	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- syrinx (congenital or acquired) (R)
63559	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- cervical radiculopathy (R)
63562	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- sciatica (R)
63565	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- spinal canal stenosis (R)
63568	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- previous spinal surgery (R)
63571	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- trauma (R)
63574	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 15 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS
†	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of one region or two contiguous regions of the spine** for monitoring of: - infection (R)
63580	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- tumour (R)
63583	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 16 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS
†	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of three contiguous regions or two non contiguous regions of the spine** for monitoring of: - infection (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63590	
†	- tumour (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63593	
	SUBGROUP 17 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR THE EXCLUSION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 17 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for the exclusion of: - tumour arising in bone or other connective tissue (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63600	
†	- infection arising in bone or other connective tissue (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63603	
†	- osteonecrosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63606	
†	- derangement of hip or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63609	
†	- derangement of shoulder or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63612	
†	- derangement of knee or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63615	
†	- derangement of ankle or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63618	
†	- derangement of temporomandibular joint or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63621	
†	- derangement of wrist or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63624	
†	- derangement of elbow or its supporting strucutres (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
63627	

	SUBGROUP 18 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 18 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for further investigation of: - tumour arising in bone or other connective tissue (R)
63650	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- infection arising in bone or other connective tissue (R)
63653	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- osteonecrosis (R)
63656	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of hip or its supporting structures (R)
63659	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of shoulder or its supporting structures (R)
63662	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of knee or its supporting structures (R)
63665	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of ankle or its supporting strucures (R)
63668	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of temporomandibular joint or its supporting structures (R)
63671	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of wrist or its supporting structures (R)
63674	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of elbow or its supporting structures (R)
63677	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- post-inflammatory or post-traumatic physeal fusion in a person under 16 years of age (R)
63680	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 19 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 19 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for monitoring of: - derangement of hip or its supporting structures (R)
63700	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of shoulder or its supporting structures (R)
63703	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- derangement of knee or its supporting structures (R)
63706	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

† 63709	- derangement of ankle or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63712	- derangement of temporomandibular joint or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63715	- derangement of wrist or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63718	- derangement of elbow or its supporting structures (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63721	- post-inflammatory or post-traumatic physeal fusion in a person under 16 years of age (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 20 - SCAN OF MUSCULOSKETAL SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS
†	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for monitoring of: - osteonecrosis (R) 63736 **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63739	- tumour arising in bone or other connective tissue (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63742	- infection arising in bone or other connective tissue (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 21 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR FURTHER INVESTIGATION OR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 21 on two occasions only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of musculoskeletal system** for further investigation or monitoring of: - Gaucher disease (R) 63745 **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 22 - SCAN OF CARDIOVASCULAR SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 22 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for further investigation of: - congenital disease of the heart or a great vessel (R) 63750 **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63753	- tumour of the heart or a great vessel (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

† 63756	- abnormality of thoracic aorta (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 23 - SCAN OF CARDIOVASCULAR SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 23 on two occasions only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast (including Magnetic Resonance Angiography if performed), performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for monitoring of:
63800	- congenital disease of the heart or a great vessel (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63803	- tumour of the heart or a great vessel (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63806	- abnormality of the thoracic aorta (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 24 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR THE EXCLUSION OF OR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 24 on two occasions only in a 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for exclusion of or further investigation of:
63850	- stroke (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63853	- carotid or verteral artery dissection (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63856	- intracranial aneurysm (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63859	- intracranial arteriovenous malformation (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63862	- venous sinus thrombosis (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63865	- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
† 63868	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) **Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 25 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for services covered by Subgroup 25 on one occasion only in a 12 month period** MAGNETIC RESONANCE ANGIOGRAPHY with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system of a person under the age of 16 years** for further investigation of: - the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R)
63870	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 26 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	MAGNETIC RESONANCE ANGIOGRAPHY with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of cardiovascular system** for monitoring of: - carotid or vertebral artery dissection (R)
63880	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- venous sinus thrombosis (R)
63883	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 27 - SCAN OF BODY - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
†	**NOTE: Benefits are payable for services covered by Subgroup 27 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body of a person under the age of 16 years** for further investigation of: - pelvic or abdominal mass (R)
63900	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- mediastinal mass (R)
63903	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- congenital uterine or anorectal abnormality (R)
63906	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- Gaucher disease (R)
63909	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

	SUBGROUP 28 - SCAN OF BODY - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS
†	**NOTE: Benefits are payable for the service covered by item 63920 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body** for further investigation of: - adrenal mass in a patient with a malignancy which is otherwise resectable (R)
63920	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 29 - SCAN OF BODY - FOR MONITORING OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
†	**NOTE: Benefits are payable for the service covered by item 63930 on one occasion only in a 12 month period** MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body of a person under the age of 16 years** for monitoring of: - congenital uterine or anorectal abnormality (R)
63930	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
	SUBGROUP 30 - SCAN OF BODY - FOR MONITORING OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS
†	MAGNETIC RESONANCE IMAGING with or without intravenous contrast, performed under the professional supervision of an eligible provider at an eligible location where the patient is referred by a specialist or by a consultant physician and where the request for the scan specifically identifies the clinical indication for the scan - **scan of the body of a person under the age of 16 years** for monitoring of: - mediastinal mass (R)
63940	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- pelvic or abdominal mass (R)
63943	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90
†	- Gaucher disease (R)
63946	**Fee:** $475.00 **Benefit:** 75% = $356.25 85% = $424.90

COMMONWEALTH OF AUSTRALIA
Health Benefits Division
Canberra ACT 2606

Commonwealth Department of
Health and
Family Services

NEW ARRANGEMENTS FOR FUNDING MAGNETIC RESONANCE IMAGING (MRI) SERVICES UNDER MEDICARE BENEFITS SCHEDULE FROM 1 SEPTEMBER 1998

New arrangements for funding of Magnetic Resonance Imaging (MRI) services will come into effect from 1 September 1998. At this time, Medicare Benefits will be introduced for a range of MRI services.

The new arrangements have been developed in response to the recommendations of the Australian Health Technology Advisory Committee's (AHTAC) "Review of Magnetic Resonance Imaging". They expand Government funding to a range of MRI services provided in both the public and private sectors. Previously, Government funding was limited to 18 public hospital units via Health Program Grants.

To assist you in understanding the new arrangements, a booklet entitled *Magnetic Resonance Imaging (MRI) Medicare Benefits Schedule Items As At 1 September 1998* is enclosed.

The new arrangements contain a series of measures to promote quality, appropriate and cost effective use and practice in line with AHTAC's recommendations. An overview of the key features of the arrangements is provided below.

MBS Itemisation

A range of Medicare Benefits Schedule (MBS) items for MRI applications has been developed to reflect AHTAC's findings on the evidence of the clinical role and value of MRI. Items are for specific clinical indications with numbers of scans specified in a 12-month period consistent with clinical practice for particular conditions.

Referral Arrangements

MRI will continue to be a service requiring a referral by a specialist or consultant physician. Requests must specify in writing the clinical indications for the scan. Oral and maxillofacial surgeons are able to request scans of the temporomandibular joint.

Provider Eligibility Requirements

Providers need to satisfy a number of requirements in order to be eligible to provide MRI services under the Medicare Benefits arrangements:

- providers must be specialists in diagnostic radiology, participating in the Royal Australasian College of Radiologist's Quality and Accreditation Program;

- services must be performed under the professional supervision of an eligible MRI provider
  - this measure to promote quality standard of service has been developed and endorsed by the Royal Australasian College of Radiologists
  - a full definition of professional supervision is provided in the explanatory notes in the booklet;

- services must be provided on eligible equipment
  - this is equipment that is in a hospital or medical practice that offers a range of diagnostic imaging procedures
  - as a minimum, X-ray, ultrasound and computerised tomography (CT) procedures are needed to meet this requirement
  - this requirement is consistent with AHTAC's recommendation and is to facilitate selection of the most suitable imaging modality for a particular condition;

- eligible equipment must have been installed in a medical practice or hospital before 7.30 pm on 12 May 1998, Eastern Standard Time; or although uninstalled, have been purchased or leased before that time on that day under a contract, in writing, that did not contain an option to cancel the contract
  - this is in recognition of AHTAC's findings that there is currently an overcapacity of MRI in Australia;

- upgrading and replacement of eligible equipment is permitted to promote quality service provision
  - any services provided on the original equipment would then cease to be eligible to attract Medicare Benefits.

MRI providers wishing to be eligible for Medicare payment purposes are required to satisfy the Health Insurance Commission of eligibility and lodge a statutory declaration.

Detailed information on eligibility requirements has been sent to diagnostic radiologists. Radiologists not receiving this information should contact the Health Insurance Commission on 132 150.

Adjustment and Relocation Scheme

As part of the new arrangements, an Adjustment and Relocation Scheme is being developed to assist in sectoral adjustment to the new arrangements and to encourage the relocation of MRI services to under serviced areas.

Medicare Schedule Fee

The schedule fee for MRI is $475. This fee contains a component towards capital costs.

MRI-related Anaesthesia Services

Access to MBS item 18013 has been extended to cover cases where anaesthesia is required in conjunction with MRI items.

New Clinical Applications of MRI

New applications of MRI beyond those included in the Medicare Benefits Schedule, will require assessment by the Medicare Services Advisory Committee (MSAC). The MSAC Secretariat can be contacted on (02) 6289 4488 or Email msac.secretariat@health.gov.au

Review

These arrangements will be reviewed within 18 months. During this time, data will be collected on MRI clinical use and delivery and some support will be provided for research into the clinical role and value of MRI and other diagnostic imaging modalities.

Further Information

Further information about the new arrangements may be obtained from:

- The Health Information Line (Freecall) – 1800 020 613;
- The Health Insurance Commission's (HIC) Provider Liaison Area – 132 150;
- The Department of Health and Family Services (DHFS) by Internet e-mail mri@health.gov.au

A list of MRI items is also recorded in an ASCII text file on the Department of Health and Family Services' Website (http://www health.gov.au). To access this file select "HFS Publications" from the main page, go to "Health Economics/Insurance/Medicare" and then select "MBS ASCIItext file [MONTH]".

These items will appear in the next edition of the Medicare Benefits Schedule.

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

Supplement to

MEDICARE BENEFITS SCHEDULE BOOK

OF 1 NOVEMBER 1997

EFFECTIVE 1 JULY 1998

COMMONWEALTH DEPARTMENT OF HEALTH AND FAMILY SERVICES

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Commonwealth Department of Health and Family Services
Canberra

SUPPLEMENT TO 1 NOVEMBER 1997 MEDICARE BENEFITS SCHEDULE BOOK

AMENDMENTS EFFECTIVE 1 JULY 1998

This supplement provides details of changes to the 1 November 1997 edition of the Medicare Benefits Schedule book. Any item not included in the summary of changes listed herein remains as it is shown in the 1 November 1997 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:-

- **psychiatric attendances** (amendment to items covering consultations in rooms to specify a "calendar year" for the purposes of the restriction contained in these items)
- **consultant occupational physician attendances** (new items)
- **carbon-labelled urea breath testing** (amendment to item description to cater for remote collection)
- **prolonged whole body perfusion** (fee increase)
- **obstetrics** (addition of anaesthetic unit values to items covering foetal blood sampling and transfusion)
- **assistance in the administration of an anaesthetic** (new item to cover assistance at elective anaesthesia in certain circumstances)
- **administration of an anaesthetic** (correction of fees and the inclusion of an item to cover the administration of anaesthesia where the associated procedure has not been allocated anaesthetic units)
- **regional or field nerve blocks** (addition of ankle and foot surgery to items covering peri-operative blocks in conjunction with knee surgery)
- **surgical operations** -
  - amendment to items covering ***repair of wound*** to clarify that these items do not apply to wound closure at time of surgery;
  - restructure of ***head and neck surgery*** services including a series of new items to cover excision of lymph nodes, a revision of tracheostomy items, and specific items for excision of parapharyngeal and aerodigestive tract tumours;
  - minor amendments to ***vascular surgery*** items covering ligation of arteries and resection of carotid tumours;
  - revision of ***cardio-thoracic surgery*** services including (i) new items to cover operative management of acute infective endocarditis in association with heart valve surgery and adjustment and repositioning of extra-corporeal membrane oxygenation cannulae (ii) amendments to arrhythmia surgery to provide for insertion of transvenous electrode as part of an automatic defibrillator system (iii) deletion of the item covering deep hypothermia with redistribution of funding to items covering procedures on the thoracic aorta which are likely to require deep hypothermia;
  - changes to ***ophthalmology*** including (i) new items covering epithelial debridement of cornea for eliminating band keratopathy and exploration of retrobulbar aspect of orbit (ii) amendment to items covering removal of vitreous to allow for vitrectomy to be claimed with certain other intraocular procedures;
  - changes to ***plastic surgery*** items including (i) new items to cover revision ptosis surgery, (ii) amendments to items covering nipple reconstruction, blepharoplasty and rhinoplasty to include restrictions aimed at precluding the payment of benefits for cosmetic procedures (iii) restructure of items covering reduction mammaplasty (iv) renumbering of items covering osteotomy/osteectomy of jaw into a more logical sequence with amendments to clarify intent of items;
  - new items included in the ***orthopaedic surgery*** area to specifically provide for combined anterior and posterior approaches to certain spinal surgery services, and to provide benefits for the treatment of acetabular dysplasia
- **oral and maxillofacial surgery** (amendment to items covering osteotomy/osteectomy of jaw to clarify intent).

SAFETY NET

The Medicare "safety net" remains at $276.80 for the 1998 calendar year (see para 1.1 of General Explanatory Notes to the 1 November 1997 Medicare Benefits Schedule book).

SUMMARY OF CHANGES

The 1 July 1998 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)	addition/deletion (Assist.)	A

New Items

~~385~~	31400	~~31429~~	41885	48613
~~386~~	31403	31432	42543	48640
~~387~~	~~31406~~	~~31435~~	42651	50394
~~388~~	31409	~~31438~~	45520	
~~17506~~	31412	~~32507~~	45522	
~~18033~~	~~31420~~	38573	45624	
~~30246~~	~~31423~~	38627	45625	
30251	~~31426~~	~~41881~~	45639	

Ceased Items

30325 30328 32505 38574 42800 42803 45521

Amended Descriptions

300	18022	30253	42542	45617	52363
302	18210	30255	42545	45638	52366
304	18211	34103	42610	45641	52369
306	30026	34106	42611	45735	52372
308	30029	34148	42614	~~45738~~	52375
310	30032	34151	42615	~~45741~~	
312	30035	34154	42719	~~45744~~	
314	30038	~~38278~~	42722	~~45747~~	
316	30041	38521	42725	45752	
318	30042	38524	42860	45761	
319	30045	41883	42863	45764	
12533	30048	41884	42866	51315	
18021	30049	42510	45545	52360	

Amended Anaesthetics

16606 16609 16612 16615

Amended Fees

13604	17989	18010	18027	18105	38556
17965	17992	18013	18030	18109	38559
17968	17995	18016	18031	18113	38562
17974	17998	18019	18032	18118	38565
17980	18001	18021	18035	18119	38568
17983	18004	18022	18102	38550	38571
17986	18007	18026	18103	38553	45623

Item Number Change

Old	New	Old	New
38250	38278	45722	~~45729~~
38253	~~38281~~	45743	~~45732~~
38259	~~38284~~	45734	45735
38530	~~38287~~	45746	~~45738~~
38533	~~38290~~	45737	~~45741~~
38536	~~38293~~	45749	45744
45725	~~45720~~	45740	~~45747~~
45719	~~45723~~		
45728	~~45726~~		

(Assist.) added to Item

42710

NOTES FOR GUIDANCE

Consultant Occupational Physician attendances (Items 385 to 388)
Attendances by consultant occupational physicians will attract Medicare benefits only where the attendance relates to one or more of the following:

i) evaluation and assessment of a patient's rehabilitation requirements where the patient presents with an accepted medical condition(s) which may be affected by his/her working environment or employability; or
ii) management of accepted medical condition(s) which may affect a patient's capacity for continued employment or return to employment following a <u>non-compensable</u> accident, injury or ill-health; or
iii) evaluation and opinion and/or management of a patient's medical condition(s) where causation may be related to acute or chronic exposures from scientifically accepted environmental hazards or toxins.

Loading of implanted pump or reservoir with a therapeutic agent/s (Item 13939)
The fee for Item 13939 includes a component to cover accessing of the drug delivery device. Accordingly, benefits are not payable under Item 13945 (Long-term implanted drug delivery device, accessing of) in addition to Item 13939.

Assistance in the administration of elective anaesthesia (Item 17506)
For the purposes of Item 17506, a "complex paediatric case" involves one or more of the following:-

(i) the need for invasive monitoring (intravascular or transoesophageal); or
(ii) organ transplantation; or
(iii) craniofacial surgery; or

(iv) major tumour resection; or
(v) separation of conjoint twins.

Anaesthetic in connection with procedure not allocated anaesthetic units (Item 18033)
Claims for benefits under Item 18033 should be submitted to Medicare for approval of benefits and should include full details confirming the clinical need for anaesthesia.

Gastrointestinal endoscopic procedures (Items 30473-30481, 30484-30487, 30490-30494, 32084-32095)
The following are guidelines of appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures
Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;
(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and
(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment
Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.

These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the Notes for Guidance in the 1 November 1997 Medicare Benefits Schedule).

Dissection of lymph nodes of neck (Items 31423 to 31438)
For the purposes of these items, the lymph node levels referred to are as follows:-

Level I -	Submandibular and submental lymph nodes
Level II -	Lymph nodes of the upper aspect of the neck including the jugulodigastric node, upper jugular chain nodes and upper spinal accessory nodes
Level III -	Lymph nodes deep to the middle third of the sternomastoid muscle consisting of mid jugular chain nodes, the lower most of which is the jugulo-omohyoid node, lying at the level where the omohyoid muscle crosses the internal jugular vein
Level IV -	Lower jugular chain nodes, including those nodes overlying the scalenus anterior muscle
Level V -	Posterior triangle nodes, which are usually distributed along the spinal accessory nerve in the posterior triangle

Comprehensive dissection involves all 5 neck levels while ***selective*** dissection involves the removal of only certain lymph node groups, for example:-

Item 31426 (removal of 3 lymph node levels) - e.g. supraomohyoid neck dissection (levels I-III) or lateral neck dissection (levels II-IV).

Item 31429 (removal of 4 lymph node levels) - e.g. posterolateral neck dissection (levels II-V) or anterolateral neck dissection (levels I-IV)

Other combinations of node levels may be removed according to clinical circumstances.

Rhinoplasty - Item 45639
Item 45639 applies where surgery is indicated for the correction of significant developmental deformity. Claims for benefits under this item should be accompanied by full clinical details, including photographs taken before and after treatment. Claims should be lodged with Medicare in the usual manner. Clinical details and photographs should be in a sealed envelope marked "Medical-In-Confidence".

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 July 1998 and continues beyond that date, the old (1 November 1997) 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 A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

‡

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, CONSULTING ROOMS
(Professional attendance by a consultant physician in the practice of his or her speciality of PSYCHIATRY where the patient is referred to him or her by a medical practitioner)

- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.

300 **Fee:** $32.30 **Benefit:** 75% = $24.25 85% = $27.50

‡ - An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.

302 **Fee:** $64.60 **Benefit:** 75% = $48.45 85% = $54.95

‡ - An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.

304 **Fee:** $94.70 **Benefit:** 75% = $71.05 85% = $80.50

‡ - An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.

306 **Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10

‡ - An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year.

308 **Fee:** $159.25 **Benefit:** 75% = $119.45 85% = $135.40

‡ - An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.

310 **Fee:** $16.15 **Benefit:** 75% = $12.15 85% = $13.75

‡ - An attendance of more than 15 minutes duration but not more than 30 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.

312 **Fee:** $32.30 **Benefit:** 75% = $24.25 85% = $27.50

‡ - An attendance of more than 30 minutes duration but not more than 45 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.

314 **Fee:** $47.35 **Benefit:** 75% = $35.55 85% = $40.25

‡ - An attendance of more than 45 minutes duration but not more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.

316 **Fee:** $65.35 **Benefit:** 75% = $49.05 85% = $55.55

‡ - An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which items 300, 302, 304, 306, 308, 310, 312, 314, 316 or 318 apply exceed 50 attendances in a calendar year.

318 **Fee:** $79.65 **Benefit:** 75% = $59.75 85% = $67.75

‡ 319	- An attendance of more than 45 minutes duration at consulting rooms, where the patient has: (i) been diagnosed as suffering severe personality disorder, anorexia nervosa, bulimia nervosa, dysthymic disorder, substance-related disorder, somatoform disorder or a pervasive development disorder; and (ii) for persons 18 years and over, been rated with a level of functional impairment within the range 1 to 50 according to the Global Assessment of Functioning Scale where that attendance and any other attendance to which items 300 to 308 apply do not exceed 160 attendances in a calendar year. *(See para A.16 of explanatory notes to this Category)* **Fee:** $130.70 **Benefit:** 75% = $98.05 85% = $111.10
	GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
† 385	**CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - SURGERY OR HOSPITAL** (Professional attendance at consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner) **-INITIAL** attendance in a single course of treatment **Fee:** $63.90 **Benefit:** 75% = $47.95 85% = $54.35
† 386	- Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $32.00 **Benefit:** 75% = $24.00 85% = $27.20
† 387	**CONSULTANT OCCUPATIONAL PHYSICIAN, REFERRED CONSULTATION - HOME VISITS** (Professional attendance at a place other than consulting rooms or hospital by a consultant occupational physician in the practice of his or her specialty of occupational medicine where the patient is referred to him or her by a medical practitioner) **- INITIAL** attendance in a single course of treatment **Fee:** $93.65 **Benefit:** 75% = $70.25 85% = $79.65
† 388	- Each attendance **SUBSEQUENT** to the first in a single course of treatment **Fee:** $59.25 **Benefit:** 75% = $44.45 85% = $50.40
	GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)
‡ 12533	CARBON-LABELLED UREA BREATH TEST using oral C-13 or C-14 urea, performed by a specialist or consultant physician, including the measurement of exhaled $^{13}CO_2$ or $^{14}CO_2$, 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 ulcer disease, or where the diagnosis of peptic ulcer has been made on barium meal; or (ii) in patients with past history of duodenal ulcer, gastric ulcer or gastric neoplasia, where endoscopy is not indicated, OR (b) the monitoring of the success of eradication of *Helicobactor pylori* in patients with peptic ulcer disease - where any request for the test by another medical practitioner who collects the breath sample specifically identifies in writing one or more of the clinical indications for the test **Fee:** $63.15 **Benefit:** 75% = $47.40 85% = $53.70
	GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES
	SUBGROUP 7 - PERFUSION
+ 13604	PROLONGED WHOLE BODY PERFUSION, CARDIAC BY-PASS, using heart-lung machine or equivalent, where the time for the procedure exceeds 6 hours *(See para T1.4 of explanatory notes to this Category)* **Derived Fee:** An amount of $526.10 plus $14.20 for each additional 10 minutes (or part thereof) beyond 6 hours

	GROUP T4 - OBSTETRICS
@ 16606	FOETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or foetus, including foetal neuromuscular blockade and amniocentesis (Anaes. 17707 = 4B + 3T) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $181.60 **Benefit:** 75% = $136.20 85% = $154.40
@ 16609	FOETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling (Anaes. 17712 = 4B + 8T) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $370.35 **Benefit:** 75% = $277.80 85% = $320.25
@ 16612	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes. 17711 = 4B + 7T) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $291.45 **Benefit:** 75% = $218.60 85% = $247.75
@ 16615	FOETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and foetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes. 17710 = 4B + 6T) *(See para T4.5 of explanatory notes to this Category)* **Fee:** $155.15 **Benefit:** 75% = $116.40 85% = $131.90
	GROUP T5 - ASSISTANCE IN THE ADMINISTRATION OF AN ANAESTHETIC
† 17506	Assistance in the administration of an elective anaesthetic, where: (i) the patient has complex airway problems; or (ii) the patient is a neonate or a complex paediatric case; or (iii) there is anticipated to be massive blood loss (greater than 50% of blood volume) during the procedure; or (iv) the patient is critically ill, with multiple organ failure; and - where the anaesthesia time is expected to exceed 6 hours and the assistance is provided to the exclusion of all other patients **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
+ 17965	- In connection with radiotherapy (Anaes. = 7B + 4T) **Fee:** $156.20 **Benefit:** 75% = $117.15 85% = $132.80
+ 17968	- In connection with forceps delivery, vacuum extraction delivery, breech delivery by manipulation or rotation of head followed by delivery (Anaes. = 5B + 3T) **Fee:** $113.60 **Benefit:** 75% = $85.20 85% = $96.60
+ 17974	- Where the anaesthetic is administered as a therapeutic procedure (Anaes. = 5B + 5T) **Fee:** $142.00 **Benefit:** 75% = $106.50 85% = $120.70
+ 17980	- In connection with computerised tomography - brain scan with or without contrast medium study (Anaes. = 7B + 4T) **Fee:** $156.20 **Benefit:** 75% = $117.15 85% = $132.80
+ 17983	- In connection with computerised tomography - body scan with or without contrast medium study (Anaes. = 7B + 4T) **Fee:** $156.20 **Benefit:** 75% = $117.15 85% = $132.80
+ 17986	- In connection with the removal of phaeochromocytoma (Anaes. = 10B + 15T) **Fee:** $355.00 **Benefit:** 75% = $266.25 85% = $304.90

ANAESTHETICS		MEDICAL SERVICE
+ 17989	- In connection with peripheral venous cannulation (Anaes. = 3B + 2T) **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35	
+ 17992	- In connection with peripheral venous cannulation by open exposure (Anaes. = 3B + 2T) **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35	
+ 17995	- In connection with percutaneous central venous cannulation (Anaes. = 5B + 2T) **Fee:** $99.40 **Benefit:** 75% = $74.55 85% = $84.50	
+ 17998	- In connection with electrocochleography (insertion of electrodes and brain stem evoked response audiometry) (Anaes. = 5B + 7T) **Fee:** $170.40 **Benefit:** 75% = $127.80 85% = $144.85	
+ 18001	- In connection with manual removal of products of conception, treatment of postpartum haemorrhage or repair of third degree tear (Anaes. = 4B + 3T) **Fee:** $99.40 **Benefit:** 75% = $74.55 85% = $84.50	
+ 18004	- In connection with repair of extensive laceration or lacerations of cervix or manipulative correction of acute inversion of uterus by vaginal approach (Anaes. = 4B + 4T) **Fee:** $113.60 **Benefit:** 75% = $85.20 85% = $96.60	
+ 18007	- In connection with Caesarean section (Anaes. = 10B + 5T) **Fee:** $213.00 **Benefit:** 75% = $159.75 85% = $181.05	
+ 18010	- In connection with repair of episiotomy (Anaes. = 3B + 2T) **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35	
+ 18013	- In connection with magnetic resonance imaging services provided at prescribed locations (Anaes. = 7B + 7T) **Fee:** $198.80 **Benefit:** 75% = $149.10 85% = $169.00	
+ 18016	- In connection with a regional or field nerve block covered by items 18216, 18219, 18230, 18232, 18233, 18234, 18236, 18242, 18262, 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:** $113.60 **Benefit:** 75% = $85.20 85% = $96.60	
+ 18019	- For incision and drainage of large haematoma, large abscess, cellulitis or similar lesion causing life threatening airway obstruction, or for the relief of life threatening airway obstruction due to epiglottitus (Anaes. = 15B + 4T) **Fee:** $269.80 **Benefit:** 75% = $202.35 85% = $229.35	
‡+ 18021	- In connection with muscle biopsy for malignant hyperpyrexia (Anaes. = 10B + 3T) **Fee:** $184.60 **Benefit:** 75% = $138.45 85% = $156.95	
‡+ 18022	- In connection with digital subtraction angiography (Anaes. = 7B + 3T) **Fee:** $142.00 **Benefit:** 75% = $106.50 85% = $120.70	
+ 18026	- During hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (Anaes. = 8B + 6T) **Fee:** $198.80 **Benefit:** 75% = $149.10 85% = $169.00	
+ 18027	- During hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (Anaes. = 15B + 11T) **Fee:** $369.20 **Benefit:** 75% = $276.90 85% = $319.10	
+ 18030	- Performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been allocated anaesthetic units where the anaesthesia time is up to and including 30 minutes (Anaes. = 4B + 2T) **Fee:** $85.20 **Benefit:** 75% = $63.90 85% = $72.45	
+ 18031	- Performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been allocated anaesthetic units where the anaesthesia time exceeds 30 minutes and is up to and including 60 minutes (Anaes. = 4B + 4T) **Fee:** $113.60 **Benefit:** 75% = $85.20 85% = $96.60	

ANAESTHETICS	DENTAL SERVICE
+ 18032	- Performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been allocated anaesthetic units where the anaesthesia time exceeds 60 minutes (Anaes. = 4B + 5T) **Fee:** $127.80 **Benefit:** 75% = $95.85 85% = $108.65
† 18033	- In connection with a procedure covered by an item which has not been allocated anaesthetic units, not being a service to which item 18030, 18031 or 18032 applies, where it can be demonstrated that there is a clinical need for anaesthesia **Derived Fee:** $56.80 (4 basic units) plus $14.20 for each 15 minutes of anaesthesia time
+ 18035	- In connection with a change of dressing or change of plaster undertaken in a hospital or approved day hospital facility (Anaes. = 3B + 2T) **Fee:** $71.00 **Benefit:** 75% = $53.25 85% = $60.35
	SUBGROUP 3 - ADMINISTRATION OF AN ANAESTHETIC IN CONNECTION WITH A DENTAL SERVICE
+ 18102	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC in connection with a dental operation other than for the extraction of teeth or restorative dental work where the procedure is less than 15 minutes duration (Anaes. = 5B + 1T) **Fee:** $85.20 **Benefit:** 75% = $63.90 85% = $72.45
+ 18103	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC in connection with a dental operation other than for the extraction of teeth or restorative dental work where the procedure is more than 15 minutes duration (Anaes. = 5B + 3T) **Fee:** $113.60 **Benefit:** 75% = $85.20 85% = $96.60
+ 18105	ADMINISTRATION by a medical practitioner OF AN ANAESTHETIC for extraction of a tooth or teeth, not being a service to which item 18109 applies (Anaes. = 5B + 2T) **Fee:** $99.40 **Benefit:** 75% = $74.55 85% = $84.50
+ 18109	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for removal of a tooth or teeth requiring incision of soft tissue and removal of bone (Anaes. = 5B + 4T) **Fee:** $127.80 **Benefit:** 75% = $95.85 85% = $108.65
+ 18113	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for restorative dental work where the procedure is of not more than 30 minutes duration (Anaes. = 5B + 2T) **Fee:** $99.40 **Benefit:** 75% = $74.55 85% = $84.50
+ 18118	ADMINISTRATION by a medical practitioner of an ANAESTHETIC for restorative dental work where the procedure is of more than 30 minutes duration (Anaes. = 5B + 6T) **Fee:** $156.20 **Benefit:** 75% = $117.15 85% = $132.80
+ 18119	ADMINISTRATION by a medical practitioner of an ANAESTHETIC in connection with a dental operation where the procedure is of more than 3 hours duration (Anaes. = 5B + 12T) **Fee:** $241.40 **Benefit:** 75% = $181.05 85% = $205.20
	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, ankle or foot surgery *(See para T7.4 of explanatory notes to this Category)* **Fee:** $33.15 **Benefit:** 75% = $24.90 85% = $28.20
‡ 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, ankle or foot surgery *(See para T7.4 of explanatory notes to this Category)* **Fee:** $39.75 **Benefit:** 75% = $29.85 85% = $33.80

GROUP T8 - SURGICAL OPERATIONS

SUBGROUP 1 - GENERAL

‡ 30026	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes. 17706 = 4B + 2T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $38.95 **Benefit:** 75% = $29.25 85% = $33.15
‡ 30029	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes. 17706 = 4B + 2T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $67.20 **Benefit:** 75% = $50.40 85% = $57.15
‡ 30032	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes. 17709 = 4B + 5T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $61.60 **Benefit:** 75% = $46.20 85% = $52.40
‡ 30035	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes. 17709 = 4B + 5T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60
‡ 30038	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), superficial, not being a service to which another item in Group T4 applies (Anaes. 17709 = 4B + 5T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $67.20 **Benefit:** 75% = $50.40 85% = $57.15
‡ 30041 G 30042 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, not on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue, not being a service to which another item in Group T4 applies (Anaes. 17709 = 4B + 5T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $107.55 **Benefit:** 75% = $80.70 85% = $91.45 **Fee:** $138.70 **Benefit:** 75% = $104.05 85% = $117.90
‡ 30045	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes. 17709 = 4B + 5T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $87.75 **Benefit:** 75% = $65.85 85% = $74.60
‡ 30048 G 30049 S	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF WOUND OF, other than wound closure at time of surgery, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes. 17709 = 4B + 5T) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $111.80 **Benefit:** 75% = $83.85 85% = $95.05 **Fee:** $138.70 **Benefit:** 75% = $104.05 85% = $117.90
† 30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $515.05 **Benefit:** 75% = $386.30 85% = $464.95
† 30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes. 17723 = 5B + 18T) (Assist.) **Fee:** $1,435.00 **Benefit:** 75% =$1,076.25 85% =$1,384.90
‡ 30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $622.85 **Benefit:** 75% = $467.15 85% = $572.75

‡ 30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $829.35 **Benefit:** 75% = $622.05 85% = $779.25
† 31400	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR up to 20mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $195.00 **Benefit:** 75% = $146.25 85% = $165.75
† 31403	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 20mm and up to 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes. 17716 = 6B + 10T) (Assist.) **Fee:** $225.00 **Benefit:** 75% = $168.75 85% = $191.25
† 31406	MALIGNANT UPPER AERODIGESTIVE TRACT TUMOUR more than 40mm in diameter (excluding tumour of the lip), excision of, where histological confirmation of malignancy has been obtained (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $375.00 **Benefit:** 75% = $281.25 85% = $324.90
† 31409	PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes. 17718 = 6B + 12T) (Assist.) **Fee:** $1,165.00 **Benefit:** 75% = $873.75 85% =$1,114.90
† 31412	RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes. 17722 = 6B + 16T) (Assist.) **Fee:** $1,435.00 **Benefit:** 75% =$1,076.25 85% =$1,384.90
† 31420	LYMPH NODE OF NECK, biopsy of (Anaes. 17709 = 5B + 4T) **Fee:** $137.30 **Benefit:** 75% = $103.00 85% = $116.75
† 31423	LYMPH NODES OF NECK, selective dissection of 1 or 2 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $300.00 **Benefit:** 75% = $225.00 85% = $255.00
† 31426	LYMPH NODES OF NECK, selective dissection of 3 lymph node levels involving removal of soft tissue and lymph nodes from one side of the neck (Anaes. 17715 = 5B + 10T) (Assist.) **Fee:** $600.00 **Benefit:** 75% = $450.00 85% = $549.90
† 31429	LYMPH NODES OF NECK, selective dissection of 4 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $935.00 **Benefit:** 75% = $701.25 85% = $884.90
† 31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes. 17723 = 5B + 18T) (Assist.) **Fee:** $1,000.00 **Benefit:** 75% = $750.00 85% = $949.90
† 31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes. 17719 = 5B + 14T) (Assist.) **Fee:** $735.00 **Benefit:** 75% = $551.25 85% = $684.90
† 31438	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck with preservation of one or more of: internal jugular vein, sternocleido-mastoid muscle, or spinal accessory nerve (Anaes. 17723 = 5B + 18T) (Assist.) **Fee:** $1,165.00 **Benefit:** 75% = $873.75 85% =$1,114.90
	SUBGROUP 3 - VASCULAR
† 32507	VARICOSE VEINS, sub-fascial surgical exploration of one or more incompetent perforating veins - 1 leg - not being a service associated with a service to which item 32508, 32511, 32514 or 32517 applies (Anaes. 17708 = 3B + 5T) (Assist.) **Fee:** $398.45 **Benefit:** 75% = $298.85 85% = $348.35
‡ 34103	GREAT ARTERY OR GREAT VEIN (including subclavian, axillary, iliac, femoral or popliteal), ligation of, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes. 17715 = 6B + 9T) (Assist.) **Fee:** $308.80 **Benefit:** 75% = $231.60 85% = $262.50

‡	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508, 32511, 32514 or 32517 apply (Anaes. 17711 = 6B + 5T) (Assist.)
34106	**Fee:** $217.90 **Benefit:** 75% = $163.45 85% = $185.25
‡	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is 4cm or less in maximum diameter (Anaes. 17725 = 10B + 15T) (Assist.)
34148	**Fee:** $1,072.55 **Benefit:** 75% = $804.45 85% =$1,022.45
‡	CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or reconstruction of internal or common carotid arteries, when tumour is greater than 4cm in maximum diameter (Anaes. 17725 = 10B + 15T) (Assist.)
34151	**Fee:** $1,465.65 **Benefit:** 75% =$1,099.25 85% =$1,415.55
‡	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes. 17725 = 10B + 15T) (Assist.)
34154	**Fee:** $1,746.40 **Benefit:** 75% =$1,309.80 85% =$1,696.30
	SUBGROUP 6 - CARDIO-THORACIC
*‡	SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of (Anaes. 17711 = 6B + 5T)
38278	**Fee:** $476.95 **Benefit:** 75% = $357.75 85% = $426.85
*	PERMANENT PACEMAKER, insertion, removal or replacement of (Anaes. 17710 = 6B + 4T) *(See para T8.27 of explanatory notes to this Category)*
38281	**Fee:** $190.75 **Benefit:** 75% = $143.10 85% = $162.15
*	PERMANENT DUAL CHAMBER TRANSVENOUS ELECTRODES, insertion, removal, or replacement of (Anaes. 17713 = 6B + 7T) *(See para T8.27 of explanatory notes to this Category)*
38284	**Fee:** $625.30 **Benefit:** 75% = $469.00 85% = $575.20
	ARRHYTHMIA ABLATION
*	ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes. 17734 = 20B + 14T) (Assist.)
38287	**Fee:** $1,566.95 **Benefit:** 75% =$1,175.25 85% =$1,516.85
*	ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes. 17738 = 20B + 18T) (Assist.)
38290	**Fee:** $1,995.20 **Benefit:** 75% =$1,496.40 85% =$1,945.10
*	VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes. 17744 = 20B + 24T) (Assist.)
38293	**Fee:** $2,141.65 **Benefit:** 75% =$1,606.25 85% =$2,091.55
	ARRHYTHMIA SURGERY
‡	AUTOMATIC DEFIBRILLATOR, insertion of patches for, or insertion of transvenous endocardial defibrillation electrode for - not being a service associated with a service to which item 38213 applies (Anaes. 17721 = 15B + 6T) (Assist.)
38521	**Fee:** $786.15 **Benefit:** 75% = $589.65 85% = $736.05
‡	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of - not being a service associated with a service to which item 38213 applies (Anaes. 17712 = 6B + 6T) (Assist.)
38524	**Fee:** $214.95 **Benefit:** 75% = $161.25 85% = $182.75
+	*PROCEDURES ON THE THORACIC AORTA*
	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes. 17742 = 20B + 22T) (Assist.)
38550	**Fee:** $1,602.65 **Benefit:** 75% =$1,202.00 85% =$1,552.55

+ 38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes. 17747 = 20B + 27T) (Assist.) **Fee:** $2,030.95 **Benefit:** 75% =$1,523.25 85% =$1,980.85
+ 38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes. 17753 = 20B + 33T) (Assist.) **Fee:** $2,318.35 **Benefit:** 75% =$1,738.80 85% =$2,268.25
+ 38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes. 17747 = 20B + 27T) (Assist.) **Fee:** $1,890.00 **Benefit:** 75% =$1,417.50 85% =$1,839.90
+ 38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes. 17753 = 20B + 33T) (Assist.) **Fee:** $2,318.35 **Benefit:** 75% =$1,738.80 85% =$2,268.25
+ 38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes. 17756 = 20B + 36T) (Assist.) **Fee:** $2,600.25 **Benefit:** 75% =$1,950.20 85% =$2,550.15
+ 38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass (Anaes. 17733 = 15B + 18T) (Assist.) **Fee:** $1,391.15 **Benefit:** 75% =$1,043.40 85% =$1,341.05
+ 38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes. 17738 = 20B + 18T) (Assist.) **Fee:** $1,532.10 **Benefit:** 75% =$1,149.10 85% =$1,482.00
† 38573	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes. 17740 = 20B + 20T) (Assist.) **Fee:** $1,483.80 **Benefit:** 75% =$1,112.85 85% =$1,433.70
	CIRCULATORY SUPPORT PROCEDURES
† 38627	EXTRA-CORPOREAL MEMBRANE OXYGENATION, BYPASS OR VENTRICULAR ASSIST DEVICE CANNULAE, adjustment and re-positioning of, by open operation, in patients supported by these devices (Anaes. 17726 = 20B + 6T) (Assist.) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $449.90
	SUBGROUP 8 - EAR, NOSE AND THROAT
† 41881	TRACHEOSTOMY by open exposure of the trachea as an independent procedure (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $300.00 **Benefit:** 75% = $225.00 85% = $255.00
‡ 41883	TRACHEOSTOMY by open exposure of the trachea in association with another procedure (Anaes. 17710 = 6B + 4T) (Assist.) **Fee:** $189.75 **Benefit:** 75% = $142.35 85% = $161.30
‡ 41884	CRICOTHYROSTOMY OR TRACHEOSTOMY, by direct stab or dilation technique, using Minitrach or similar device (Anaes. 17708 = 6B + 2T) **Fee:** $67.95 **Benefit:** 75% = $51.00 85% = $57.80
† 41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes. 17714 = 6B + 8T) (Assist.) **Fee:** $215.00 **Benefit:** 75% = $161.25 85% = $182.75

SUBGROUP 9 - OPHTHALMOLOGY

‡ 42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $524.20 **Benefit:** 75% = $393.15 85% = $474.10
‡ 42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $376.25 **Benefit:** 75% = $282.20 85% = $326.15
† 42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $660.00 **Benefit:** 75% = $495.00 85% = $609.90
‡ 42545	ORBIT, decompression of, for dysthyroid eye disease, by fenestration of 2 or more walls, or by the removal of intraorbital peribulbar and retrobulbar fat from each quadrant of the orbit, 1 eye (Anaes. 17717 = 5B + 12T) (Assist.) **Fee:** $954.60 **Benefit:** 75% = $715.95 85% = $904.50
‡ 42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes. 17706 = 5B + 1T) **Fee:** $71.80 **Benefit:** 75% = $53.85 85% = $61.05
‡ 42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes. 17707 = 5B + 2T) **Fee:** $107.80 **Benefit:** 75% = $80.85 85% = $91.65
‡ 42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage, not being a service associated with a service to which item 42610 applies (excluding after-care) **Fee:** $36.00 **Benefit:** 75% = $27.00 85% = $30.60
‡ 42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage, not being a service associated with a service to which item 42611 applies (excluding after-care) **Fee:** $53.95 **Benefit:** 75% = $40.50 85% = $45.90
† 42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes. 17709 = 5B + 4T) **Fee:** $120.00 **Benefit:** 75% = $90.00 85% = $102.00
A 42710	ARTIFICIAL LENS, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (Anaes. 17712 = 6B + 6T) (Assist.) **Fee:** $673.80 **Benefit:** 75% = $505.35 85% = $623.70
‡ 42719	CAPSULECTOMY OR REMOVAL OF VITREOUS via the anterior chamber by any method, not being a service associated with a service to which item 42698, 42702 or 42716 applies (Anaes. 17712 = 8B + 4T) (Assist.) **Fee:** $387.50 **Benefit:** 75% = $290.65 85% = $337.40
‡ 42722	CAPSULECTOMY by posterior chamber sclerotomy OR REMOVAL OF VITREOUS or VITREOUS BANDS from the anterior chamber by posterior chamber sclerotomy, by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with a service to which item 42698, 42702 or 42716 applies - 1 or both procedures (Anaes. 17714 = 8B + 6T) (Assist.) **Fee:** $423.90 **Benefit:** 75% = $317.95 85% = $373.80
‡ 42725	VITRECTOMY by posterior chamber sclerotomy - including the removal of vitreous, division of bands or removal of pre-retinal membranes by cutting and suction and replacement by saline, Hartmann's or similar solution (Anaes. 17718 = 10B + 8T) (Assist.) **Fee:** $999.55 **Benefit:** 75% = $749.70 85% = $949.45
‡ 42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes. 17714 = 5B + 9T) (Assist.) **Fee:** $673.80 **Benefit:** 75% = $505.35 85% = $623.70
‡ 42863	EYELID, recession of (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $578.35 **Benefit:** 75% = $433.80 85% = $528.25
‡ 42866	ENTROPION or TARSAL ECTROPION, repair of, by tightening, shortening or repair of inferior retractors by open operation across the entire width of the eyelid (Anaes. 17713 = 5B + 8T) (Assist.) **Fee:** $561.55 **Benefit:** 75% = $421.20 85% = $511.45

SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY

† 45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $672.40 **Benefit:** 75% = $504.30 85% = $622.30
† 45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple (Anaes. 17710 = 5B + 5T) (Assist.) **Fee:** $471.70 **Benefit:** 75% = $353.80 85% = $421.60
‡ 45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes. 17710 = 5B + 5T) (Assist.) *(See para T8.53 of explanatory notes to this Category)* **Fee:** $464.90 **Benefit:** 75% = $348.70 85% = $414.80
‡ 45617	UPPER EYELID, REDUCTION OF, for skin redundancy obscuring vision (as evidenced by upper eyelid skin resting on lashes on straight ahead gaze), herniation of orbital fat in exophthalmos, facial nerve palsy or post-traumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes. 17708 = 5B + 3T) *(See para T8.56 of explanatory notes to this Category)* **Fee:** $175.55 **Benefit:** 75% = $131.70 85% = $149.25
+ 45623	PTOSIS of eyelid (unilateral), correction of (Anaes. 17709 = 5B + 4T) (Assist.) **Fee:** $540.00 **Benefit:** 75% = $405.00 85% = $489.90
† 45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes. 17711 = 5B + 6T) (Assist.) **Fee:** $700.00 **Benefit:** 75% = $525.00 85% = $649.90
† 45625	PTOSIS of eyelid, correction of eyelid height by revision of levator sutures within one week of primary repair by levator resection or advancement, performed in the operating theatre of a hospital or approved day hospital facility (Anaes. 17707 = 5B + 2T) **Fee:** $140.00 **Benefit:** 75% = $105.00 85% = $119.00
‡ 45638	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of post-traumatic deformity or nasal obstruction, or both (Anaes. 17711 = 5B + 6T) **Fee:** $757.25 **Benefit:** 75% = $567.95 85% = $707.15
† 45639	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, where it can be demonstrated that there is a need for correction of significant developmental deformity (Anaes. 17711 = 5B + 6T) **Fee:** $757.25 **Benefit:** 75% = $567.95 85% = $707.15
‡ 45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes. 17713 = 5B + 8T) **Fee:** $808.60 **Benefit:** 75% = $606.45 85% = $758.50
* 45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17718 = 10B + 8T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $721.90 **Benefit:** 75% = $541.45 85% = $671.80
* 45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17720 = 10B + 10T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $814.20 **Benefit:** 75% = $610.65 85% = $764.10
* 45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17725 = 10B + 15T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $920.10 **Benefit:** 75% = $690.10 85% = $870.00
* 45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17729 = 10B + 19T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* **Fee:** $1,033.20 **Benefit:** 75% = $774.90 85% = $983.10

*	MANDIBLE OR MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17732 = 10B + 22T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45732 **Fee:** $1,179.25 **Benefit:** 75% = $884.45 85% =$1,129.15
*‡	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17726 = 10B + 16T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45735 **Fee:** $1,203.10 **Benefit:** 75% = $902.35 85% =$1,153.00
*‡	MANDIBLE AND MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17732 = 10B + 22T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45738 **Fee:** $1,353.30 **Benefit:** 75% =$1,015.00 85% =$1,303.20
*‡	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17753 = 10B + 43T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45741 **Fee:** $1,323.45 **Benefit:** 75% = $992.60 85% =$1,273.35
*‡	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17758 = 10B + 48T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45744 **Fee:** $1,488.05 **Benefit:** 75% =$1,116.05 85% =$1,437.95
*‡	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty (when performed) and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17758 = 10B + 48T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45747 **Fee:** $1,443.80 **Benefit:** 75% =$1,082.85 85% =$1,393.70
‡	MANDIBLE AND MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17771 = 10B + 61T) (Assist.) *(See para T8.58 of explanatory notes to this Category)* 45752 **Fee:** $1,617.25 **Benefit:** 75% =$1,212.95 85% =$1,567.15
‡	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17713 = 5B + 8T) (Assist.) *(See para T8.59 of explanatory notes to this Category)* 45761 **Fee:** $559.05 **Benefit:** 75% = $419.30 85% = $508.95
‡	GENIOPLASTY being a service associated with a service to which item 45720, 45723, 45726, 45729, 45731, 45732, 45735 or 45738 applies (Anaes. 17709 = 5B + 4T) (Assist.) *(See para T8.59 of explanatory notes to this Category)* 45764 **Fee:** $325.55 **Benefit:** 75% = $244.20 85% = $276.75

	SUBGROUP 15 - ORTHOPAEDIC
† 48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes. 17743 = 13B + 30T) (Assist.) **Fee:** $2,600.00 **Benefit:** 75% =$1,950.00 85% =$2,549.90
† 48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes. 17743 = 13B + 30T) (Assist.) **Fee:** $2,600.00 **Benefit:** 75% =$1,950.00 85% =$2,549.90
† 50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes. 17728 = 10B + 18T) (Assist.) **Fee:** $2,073.90 **Benefit:** 75% =$1,555.45 85% =$2,023.80
	GROUP T9 - ASSISTANCE AT OPERATIONS
‡ 51315	Assistance at cataract and intraocular lens surgery covered by items 42698,42701, 42702, 42704, 42707, when performed in association with services covered by items 42551 to 42569, 42653, 42656, 42746, 42749, 42752, 42776 or 42779 **Fee:** $203.40 **Benefit:** 75% = $152.55 85% = $172.90
	GROUP O4 - PLASTIC & RECONSTRUCTIVE
‡ 52360	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17726 = 10B + 16T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,203.10 **Benefit:** 75% = $902.35 85% =$1,153.00
‡ 52363	MANDIBLE and MAXILLA, osteotomies or osteectomies of, involving 2 such procedures of each jaw, including transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17732 = 10B + 22T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,353.30 **Benefit:** 75% =$1,015.00 85% =$1,303.20
‡ 52366	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17753 = 10B + 43T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,323.45 **Benefit:** 75% = $992.60 85% =$1,273.35
‡ 52369	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of 1 jaw and 2 such procedures of the other jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17758 = 10B + 48T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,488.05 **Benefit:** 75% =$1,116.05 85% =$1,437.95
‡ 52372	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site (Anaes. 17758 = 10B + 48T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,443.80 **Benefit:** 75% =$1,082.85 85% =$1,393.70
‡ 52375	MANDIBLE and MAXILLA, complex bilateral osteotomies or osteectomies of, involving 3 or more such procedures of each jaw, including genioplasty when performed and transposition of nerves and vessels and bone grafts taken from the same site and rigid fixation by bone plates, screws or both (Anaes. 17771 = 10B + 61T) (Assist.) *(See para OC. of explanatory notes to this Category)* **Fee:** $1,617.25 **Benefit:** 75% =$1,212.95 85% =$1,567.15