

Commonwealth Department of Health and Ageing

Medicare Benefits Schedule Book

Operating from 1 November 2002

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



BOOK LAYOUT

This book contains the following Sections, colour coded as indicated:-

- . **Contents (black edging)**
- . **Introduction**
- . **Summary of Changes included in this Edition**
- . **General Explanatory Notes**
(Includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)
- . **General Medical Services comprising**
 - Professional Attendances ([Category 1](#)) - (buff edging)
 - Diagnostic Services ([Category 2](#)) - (blue edging)
 - Relative Value Guide (within [Category 3](#)) - (teal edging)
 - Therapeutic Procedures ([Category 3](#)) - (red edging)*(Includes specific explanatory notes preceding each category)*
- . **Index to General Medical Services (green edging)**
- . **Approved Dental Practitioner Services ([Category 4](#)) - (grey edging)**
(Includes an outline of these arrangements, specific explanatory notes and an index)
- . **Diagnostic Imaging Services ([Category 5](#)) - (purple edging)**
(Includes an outline of these arrangements, specific explanatory notes and an index)
- . **Pathology Services ([Category 6](#)) - (yellow edging)**
(Includes an outline of these arrangements, specific explanatory notes and an index)



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INTRODUCTION

The book is divided into the following sections :-

- . **General Explanatory Notes**
(includes an outline of the Medicare benefit arrangements and general notes for guidance for all services)
- . **General Medical Services** comprising
 - **Professional Attendances** (Category 1) - **(buff edging)**
 - **Diagnostic Services** (Category 2) - **(blue edging)**
 - **Therapeutic Procedures** (Category 3) - **(red edging)**
 - **Relative Value Guide (within Category 3) - (peacock edging)**
(includes specific explanatory notes preceding each Category)
- . **Index to General Medical Services (green edging)**
- . **Approved Dental Practitioner Services** (Category 4) - **(grey edging)**
(includes an outline of these arrangements, specific explanatory notes and an index)
- . **Diagnostic Imaging Services** (Category 5) - **(purple edging)**
(includes an outline of these arrangements, specific explanatory notes and an index)
- . **Pathology Services** (Category 6) - **(yellow edging)**
(includes an outline of these arrangements, specific explanatory notes and an index)

Schedules of Services

Each professional service contained in the book has been allocated a unique item number, which may be found by reference to the alphabetical listing of services in the relevant index. (For services not listed in the Schedule or services which do not attract Medicare benefits see paragraphs 11 and 13 of the General Explanatory Notes)

Located with the item number and description for each service is the Schedule fee and Medicare benefit, together with a reference to an explanatory note relating to the item if applicable. If the service attracts an anaesthetic, the word (Anaes.) appears following the description.

Where an operation qualifies for the payment of benefits for an assistant, the relevant items are identified by the inclusion of the word Assist. in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

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

Higher rates of benefits are also provided for consultations by a recognised consultant physician where the patient has been referred by another medical practitioner or an approved dental practitioner (oral surgeons). For conditions of referral see paragraph 6 of the General Explanatory Notes.

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

Structure of Schedule of Services

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

Explanatory Notes

Explanatory notes relating to the Medicare benefit arrangements and notes that have general application to services are located at the beginning of the book, while notes relating to specific items are located at the beginning of each Category. While there may be a reference following the description of an item to specific notes relating to that item, there may also be general notes relating to each Group of items.

Schedule Interpretations

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

NSW - 132 150	WA - 132 150
VIC - 03 9605 7964	TAS - 03 6215 5740
QLD - 07 3004 5280	ACT - 02 6124 6362
SA - 08 8274 9788	NT - use South Australia number

Changes to Provider Details

It is important that the Health Insurance Commission be notified promptly of changes to practice addresses to ensure correct provider details for each practice location. Addresses of the Commission are listed at paragraph 2.9 of the General Explanatory Notes of this book. (See also paragraph 2.2 of the General Explanatory Notes).

Distribution of the Medicare Benefits Schedule Book

It is also important to notify the Department of Health and Ageing of changes to mailing details to ensure receipt of the Medicare Benefits Schedule book and up-dates. Enquiries regarding distribution of the book and notification of changes of details should be directed to the Central Office of the Department, Fax (02) 6289 4996 or Freecall 1800 020103. Addresses of the State Offices of the Department are listed below. Please note that matters of interpretation of the Schedule should be directed to the Health Insurance Commission (see above).

NEW SOUTH WALES

Level 7
1 Oxford Street
SYDNEY NSW 2000
Tel (02)9263 3555

VICTORIA

2 Lonsdale Street
MELBOURNE VIC 3000
Tel (03)9665 8888

QUEENSLAND

5th Floor Samuel Griffith Building
340 Adelaide Street
BRISBANE QLD 4000
Tel (07)3360 2555

SOUTH AUSTRALIA

Commonwealth Centre
55 Currie Street
ADELAIDE SA 5000
Tel (08)8237 8111

WESTERN AUSTRALIA

152-158 St George's Terrace
PERTH WA 6000
Tel (08)93465111

TASMANIA

Montpelier Building
21 Kirksway Place
BATTERY POINT TAS 7004
Tel (03) 6221 1411

AUSTRALIAN CAPITAL TERRITORY

Alexander Building
Furzer Street
PHILLIP ACT 2606
Tel (02) 6289 1555

NORTHERN TERRITORY

Cascom Centre
13 Scaturchio Street
CASUARINA NT 0800
Tel (08) 8946 3444

Future Editions of the Medicare Benefits Schedule Book

The Department welcomes any suggestions for improvements on the layout of the Medicare Benefits Schedule book from individual practitioners. Any suggestions should be forwarded to:- The Director, Financial and Schedule Review Section, Medicare Benefits Branch, MDP 106, GPO Box 9848, Canberra ACT 2601.

Internet

The Medicare Benefits Schedule is also available on the Department of Health and Ageing's Internet site at www.health.gov.au. The site contains a viewing file and an ASCII text downloadable file of the current version of the Schedule.

SUMMARY OF CHANGES INCLUDED IN THIS EDITION

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

General Fee Increase

The following changes to Medicare schedule fees will apply from 1 November 2002:

A 2.5% increase in Schedule fees will apply to all items in Group [A1](#) plus equivalent attendance items. There has been no increase in the Schedule Fee for items in Group [A2](#) (other non-referred attendances), Group [A6](#) (group therapy), item [173](#) in Group [A7](#) (acupuncture), Group [A19](#) (PIP incentive payments, other non-referred); a 2.5% increase will apply to all other items except for Diagnostic Imaging and Pathology items; and a 2.5% increase applies to items in Group [14](#) in the Diagnostic Imaging section of the book.

Increase in Maximum Gap Payment

The maximum patient gap between the Schedule fee and the benefits payable for out-of-hospital services increases to \$57.10 as at 1 November 2002. The 85% benefit level will apply for all fees up to \$380.65, after which, benefits are calculated at the Schedule fee less \$57.10

REVIEW OF GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- Case Conferencing by Consultant Psychiatrists (new items, see note below)
- Asthma (see note below)
- Diabetes (see note below)
- Cervical Screening (see note below)
- Mental Health (see note below)
- Ophthalmology (see note below)
- Urology (see note below)
- Relative Value Guide for Anaesthesia (See note below)
- Breast Surgery (See note below)
- Vascular Surgery (See note below)
- Cardiovascular Conditions (See note below)
- Ear Nose and Throat Surgery (See note below)
- Neurosurgery (See note below)
- Emergency Medicine (See note below)

CASE CONFERENCING BY CONSULTANT PSYCHIATRISTS

A new range of case conferencing items ([855](#), [857](#), [858](#), [861](#), [864](#) and [866](#)) specifically for psychiatrists has been introduced with a requirement for three formal care providers instead of four as with other consultant physicians, because this requirement is more suited to the practice of psychiatry.

EMERGENCY MEDICINE

New items ([501](#), [503](#), [507](#), [511](#), [515](#)) have been included for emergency physicians practising in private emergency medicine departments. The new items are content based and align with emergency medicine practice in terms of complexity of care.

A further range of items ([519](#), [520](#), [530](#), [532](#), [534](#), [536](#)) has been introduced for emergency physicians for prolonged attendances in the treatment of critical conditions. The new items allow emergency physicians to attend to a number of critical patients concurrently.

ASTHMA 3+ VISIT PLAN

The item descriptors have been amended to outline in a more logical order what doctors are required to complete prior to claiming the asthma items. These amendments do not change the requirements but explain them more clearly.

The notes include a table of the National Asthma Council's (NAC) recommended 3+ Visit Plan. This table has recently been revised by the NAC so the notes have been changed to reflect this revision. Activities which doctors are required to complete prior to claiming the items have been re-ordered in line with the changes to the item descriptor.

There is a minor amendment to the tense of sentences in the notes to make current the paragraph on introduction of the PIP incentive.

DIABETES

The item descriptor has been amended to include an explanation of when to measure and assess the Body Mass Index.

The notes have been amended to reflect changes to the item descriptors and to make current the paragraph on introduction of the PIP incentive.

CERVICAL SCREENING

The notes have been amended to make current the paragraph on introduction of the PIP incentive.

MENTAL HEALTH

Items outlining the 3 Step Mental Health process and the requirements for its completion, already notified to the profession, have now been incorporated in the Schedule.

Four additional items have been introduced (Items [2721](#), [2723](#), [2725](#), and [2727](#)) for the delivery of Focussed Psychological Strategies (FPS). These items cover professional attendances of 30 minutes to less than 40 minutes duration, and 40 minutes or more duration, occurring in consultation rooms as well as in places other than consulting rooms.

Notes have been included defining FPS and stating that the services may only be provided by a medical practitioner who is registered with the Health Insurance Commission as meeting the requirements to participate in the Better Outcomes in Mental Health Care Initiative and the additional training requirement set by the General Practice Mental Health Standards Collaboration for FPS. The service must be provided in a general practice participating in the Practice Incentives Program or which is accredited.

OPHTHALMOLOGY

The word “*unidimensional*” has been added to the descriptors for items [11240-11243](#).

Changes to items [13915](#), [35317 - 35321](#) and [42809](#) introduce the restrictions on existing inappropriate items being used for Photodynamic Therapy.

UROLOGY

To clarify the intent and usage of Urodynamics item [11918](#) the descriptor has been modified and a new item [11917](#) has been introduced to define the types of diagnostic imaging services being performed.

Two new items [37201](#) and [37202](#) are currently being put forward for approval under a Ministerial Determination to implement a Medical Services Advisory Committee recommendation for transurethral needle ablation of the prostate. Items [37203 - 37208](#) have been modified to include a reference to the new items in anticipation of their introduction.

ANAESTHESIA

To maintain cost neutrality, in accordance with the Anaesthetic Agreement between the Australian Society of Anaesthetists, the Australian Medical Association, the Rural Doctors Association of Australia and the Commonwealth, the fee per unit for services included in the Relative Value Guide for Anaesthetics (Group [T10](#)) has been reduced from \$17.15 to \$16.50.

Two new items ([18226](#) and [18227](#)) have been added for obstetric epidurals provided in the after hours period.

Two new items ([20799](#) and [20886](#)) have been added for upper and lower percutaneous abdominal procedures.

Item [20855](#) has been amended to include hysterectomy within 24 hours of delivery.

Labour, Delivery and Post-Partum Care items [16515](#), [16518](#), [16519](#), [16520](#), [16522](#), [16525](#), [16564](#), [16567](#), [16570](#), [16571](#), [16573](#) have been amended to include ‘anaes’ at the end of their descriptions to facilitate the claiming of anaesthesia provided in association with these services.

Nerve block items [18216](#), [18219](#), [18230](#), [18232](#), [18233](#), [18234](#), [18236](#), [18242](#), [18262](#), [18280](#), [18284](#), [18286](#), [18288](#), [18290](#), [18292](#), [18294](#), [18296](#) and [18298](#) have been amended to include ‘anaes’ at the end of their descriptions to facilitate the claiming of anaesthesia provided in association with these services.

BREAST SURGERY

To allow funding of the Advanced Breast Biopsy Instrumentation (ABBI) procedure as recommended by the Medical Services Advisory Committee, three new items have been introduced to cover the radiological and surgical components of the procedure (Items [31539](#), [31542](#), and [31545](#)). The ABBI procedure often requires two medical practitioners, a breast surgeon and a radiologist, each with sufficient training and expertise in the procedure.

Breast biopsy items [31500](#), [31503](#), [31506](#), [31509](#), [31512](#), [31515](#), [31530](#), [31536](#) and [31548](#) have been amended to prevent their use with the ABBI procedure.

All breast surgery items (formerly 30339-30372) have been renumbered in order to allow space for the introduction of the three new ABBI items.

VASCULAR SURGERY

The descriptors for items [32504](#), [32507](#), [32508](#), [32511](#), [32514](#) and [32517](#) have been amended by adding the words 'on the same leg' or '1 leg' as appropriate, to clarify the intention of the item.

The descriptor for item [33806](#) has also been changed to add an additional phrase to clarify that the infusion of thrombolytic or other agents, where necessary, is already covered by the item. A note has been added to stipulate that benefit is payable once only per extremity, regardless of the number of incisions required to access the artery or bypass graft.

The item descriptor for blood pressure monitoring item [11600](#) has been clarified to state that it is not for use during anaesthesia. Following changes to the MBS in May 2002, item 11601 is now redundant and has been deleted.

CARDIOVASCULAR CONDITIONS

To allow funding of the Off-Pump Coronary Artery Bypass (OPCAB) and Minimally Invasive Direct Coronary Artery Bypass (MIDCAB) surgery procedures recommended by the Medical Services Advisory Committee, three new items 38498, 38501 and 38504 have been introduced. The items cover the OPCAB/MIDCAB procedures using either: vein grafts; single arterial grafts; or, two or more arterial grafts. This is an equivalent structure to that of the current coronary artery bypass grafting (CABG) items.

CABG items [38497](#), [38500](#), and [38503](#) have been amended to exclude their use when an off-pump procedure is performed and cardio-pulmonary bypass is not required. All off-pump procedures will be claimable under item numbers [38498](#), [38501](#) or [38504](#), as appropriate.

Amendments to the notes for items [38497-38504](#) have been made for consistency and to explain the requirement for a clinical or medical perfusionist to be present when the off-pump procedures are performed.

Following a negative recommendation from the Medical Services Advisory Committee in relation to intravascular ultrasound (IVUS) a note for each of the coronary angiography items [38215](#) - [38246](#) has been included stating that these items are not to be used for claiming benefits for an IVUS procedure. The angiogram items should not be claimed for IVUS and this change merely reinforces this.

EAR NOSE AND THROAT SURGERY

Items for Fenestration Operation and Venous Graft to Fenestration Cavity (41602 and 41605) have been deleted because they are obsolete.

NEUROSURGERY

Following the introduction of Deep Brain Stimulation (DBS) procedure items in February 2002 under a Ministerial determination, item descriptors for items [39134](#) and [40801](#) have been amended to prevent use of these items for the DBS procedure instead of the appropriate DBS items [40850](#) - [40862](#).

CHANGES TO DIAGNOSTIC IMAGING SERVICES

Diagnostic Radiology - Four items 57948, 57951, 57954 and 57957 have been deleted and replaced with four new items and descriptions - [57960](#), [57963](#), [57966](#), [57969](#). Refer to [DIH.4](#) of the explanatory notes for the Diagnostic Imaging Services Table.

CHANGES TO PATHOLOGY SERVICES

A number of new items have been included in the Pathology Services Table. The new items include investigation of recurrent infection (Items [71133](#) and [71134](#)) and diagnosis and monitoring of coeliac disease or other gluten hypersensitivity syndrome (Items [71160](#), [71161](#) and [71162](#)).

Parts of Groups [P3](#) (Microbiology), [P4](#) (Immunology) and [P5](#) (Tissue Pathology) have also been restructured. These restructures involve the deletion and amendment of a significant number of items.

In the Immunology Group, item 71067 has been deleted and 4 separate items have been created (Items [71066](#), [71068](#), [71072](#) and [71074](#)) detailing specific immunoglobulins.

In the Microbiology Group the hepatitis items have been significantly reduced while maintaining coverage of all antibody antigen tests done in hepatitis serology (Items [69475](#) - [69493](#)).

In the Tissue Pathology Group the changes include, scheduled fee increases for the examination of complexity levels 5 and 6 ([72830](#) and [72836](#)), amendment of specimen types for lip and skin biopsies, amendment to the complexity level for parathyroid glands, and the expansion of items [72817](#) and [72825](#). Item [72817](#) will be limited to 2 to 4 specimens and complemented by a new item ([72818](#)) allowing for the examination of 5 or more specimens. Item [72825](#) will be limited to 5 to 7 specimens and complemented by a new item ([72826](#)) allowing for the examination of 8 or more specimens.

Item 66656	(General Chemistry) - removal of restriction of 4 patient episodes in 12 months
Item 69363	(Microbiology) - addition of reference to item 69370
Item 69372	(Microbiology) - addition of reference to nucleic acids

Item 69375	(Microbiology) - addition of reference to item 69370
Item 69405	(Microbiology) - reflects the restructure of the hepatitis items
Item 69408	(Microbiology) - reflects the restructure of the hepatitis items
Item 69411	(Microbiology) - reflects the restructure of the hepatitis items
Item 71069	(Immunology) - reflects the restructure of the immunoglobulin items
Item 71071	(Immunology) - reflects the restructure of the immunoglobulin items
Item 71135	(Immunology) - reflects the addition of the oxidative pathway items (71133 and 71134)

A number of abbreviations have also been included, amended or deleted to reflect the restructuring of Groups [P3](#) (Microbiology) and [P4](#) (Immunology).

Part 1 of the Schedule (prescription of the Table) has been amended to reflect the replacement of the Licensed Collection Centres (LCC) Scheme with Approved Collection Centres (ACC) which commenced on 1 December 2001.

Part 2 of the Schedule (Rules of Interpretation) has been amended as follows:

PP.11	Reflecting the new hepatitis structure
Rule 4(2)	Inclusion of reference to leflunomide
rule 11	Reflecting the new hepatitis structure
Rule 14(1)	Reflecting the implementation of Approved Collection Centres
rule 24	Reflecting the inclusion of the gluten hypersensitivity (coeliac disease) item

SUMMARY OF CHANGES

The 1 November 2002 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) amended description ‡
- (c) fee amended +
- (d) item number change *
- (e) item attracting an anaesthetic @
- (f) items transferred from Ministerial Determination

New Items

[501](#) [503](#) [507](#) [511](#) [515](#) [519](#) [520](#) [530](#) [532](#) [534](#) [536](#) [855](#) [857](#) [858](#) [861](#) [864](#)
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[31545](#) [31548](#) [31551](#) [31554](#) [31557](#) [31560](#) [31563](#) [31566](#) [37201](#) [37202](#) [38498](#) [38501](#) [38504](#) [57960](#) [57963](#) [57966](#) [57969](#)
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[72826](#)

Deleted Items

[11601](#) [30339](#) [30340](#) [30343](#) [30344](#) [30347](#) [30348](#) [30351](#) [30352](#) [30354](#) [30355](#) [30358](#) [30360](#) [30361](#) [30363](#) [30364](#)
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Fee Amended

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Items attracting an anaesthetic

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Addition/Deletion (Assist)

40850

New Item (previous Ministerial Determination)

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Item Number Change

Old	New	Old	New	Old	New	Old	New
30339	31500	30340	31503	30343	31506	30344	31509
30347	31512	30348	31515	30351	31518	30352	31521
30354	31524	30355	31527	30358	31530	30360	31533
30361	31536	30363	31548	30364	31551	30366	31554
30367	31557	30369	31560	30370	31563	30372	31566

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

Where an item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 November 2002 and continues beyond that date, the general rule is that the 1 November 2001 level of fees and benefits would apply.

GENERAL EXPLANATORY NOTES



MEDICARE BENEFIT ARRANGEMENTS

1. OUTLINE OF SCHEME

1.1 Medicare

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

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

- automatic entitlement to benefits in respect of professional services (other than professional services to which the following dot point applies) equal to 85% of the Medicare Benefits Schedule fee, with a maximum payment of \$57.10 (indexed annually) by the patient for any one service where the Schedule fee is charged;
- for professional services rendered while hospital treatment (i.e., accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), a flat rate of benefit of 75% of the Schedule fee, that is, there is no limit to the maximum amount of gap between the benefit and the Schedule fee; and
- access to public hospital services for eligible persons who choose to be treated free of charge as public patients in accordance with the provisions of the 1998-2003 Australian Health Care Agreements.

Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee, or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund. For out-of-hospital services the maximum amount of 'gap' (i.e. the difference between the Medicare rebate and the Schedule fee) payable by a family group or an individual in any one calendar year is \$309.80 (indexed annually from 1 January). A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

1.1.3 The Health Insurance Commission is responsible for the operation of Medicare and Medicare benefits based on the services and fees contained in this book. For details of locations of Medicare offices, see paragraph 2.9 below.

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

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

1.1.6 For any service listed in the Schedule to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of medical services is strictly in accordance with the provisions of the Therapeutic Goods Act 1989.

2. PROVIDER ELIGIBILITY

2.1 Access to Medicare Benefits

2.1.1 Amendments to the Health Insurance Act 1973 which came into force in December 1996 provide that from that date, medical practitioners have to meet minimum proficiency requirements before any services they provide (except assistance at operations) can attract a Medicare benefit. To be eligible to provide a medical service which can attract a Medicare benefit, or to provide services for or on behalf of another practitioner, one of the following conditions must apply:-

- the person was a medical practitioner prior to 1 November 1996 (this does not include an intern or Australian Medical Council candidate who has not completed a required period of supervised training, a person without the legal right to be in Australia on 1 November 1996, or a person acting as a medical practitioner on a temporary visa); or
- the person is a recognised specialist, consultant physician or general practitioner;
- the person is in an approved placement under section 3GA of the Health Insurance Act 1973; or
- the person is a temporary resident doctor with a determination under Section 3J of the Health Insurance Act 1973, while working in accord with that determination (Note: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors).

2.1.2 Any practitioner who does not satisfy these requirements is not a Medical Practitioner for Medicare purposes and Medicare benefits cannot be paid for their services. This does not affect the practitioners ability to prescribe, refer, order diagnostic tests etc.

2.1.3 It is an offence under Section 19CC of the Health Insurance Act 1973 to provide a service without first informing a patient where a Medicare benefit is not payable for that service.

2.2 Provider Numbers

2.2.1 When an eligible medical practitioner wishes to have Medicare benefits payable for his/her services and/or, for Medicare purposes, wishes to raise valid

- referrals for specialist services; or
- requests for pathology or diagnostic imaging services,

the practitioner can apply in writing to the Health Insurance Commission for a Medicare provider number for the sites from which medical services/referrals/requests will be provided. A blank downloadable form is available on the Commission's website at www.hic.gov.au/prof/

2.2.2 Medicare Provider Numbers are allocated to practitioners to provide an easy method of identifying the place from which a service is provided. Health Insurance Regulations provide that, for Medicare purposes, a valid account/receipt must contain the practitioners' name and either:-

- the address of the place from which the service was provided; OR
- the provider number for the place from which the service was provided.

2.2.3 The provider number comprises a stem number which is up to 6 characters followed by a number/alpha denoting the practice location followed by an alpha character which is a check character.

2.2.4 Medical registration information is validated by medical registration authorities to ensure appropriate processing of Medicare claims.

2.2.5 Pay group arrangements are available which allow Medicare benefit cheques, which would normally be payable to a medical practitioner, to be made payable to a third party. Information about pay group links is contained in the provider number application form and is available from the Health Insurance Commission and on the Commission's website at www.hic.gov.au.

Existing pay group arrangements can be terminated by a written request from the practitioner, however, the Health Insurance Commission will routinely inform the payee of such a termination.

2.2.6 Medicare provider number information is released in accord with the secrecy provisions of the Health Insurance Act 1973 (Section 130) to authorised external organisations including Private Health Insurance Funds, the Department of Veterans' Affairs and the Department of Health and Ageing.

2.3 Locum Tenens

2.3.1 Where a locum tenens is to provide services at a practice location for more than two weeks or will be providing services at the location for less than two weeks but on a regular basis, the locum should apply for a provider number for that location. If the locum is to provide services at a practice for less than two weeks and will not be returning to that location in the future, the locum should contact the Health Insurance Commission's provider liaison area (phone 132 150) to discuss options. In some cases the locum may be able to use one of his/her other provider numbers. The use of a provider number other than the provider number allocated to the location MUST NOT apply where:

- the practitioner is an RACGP or specialist trainee with a provider number issued for an approved training placement; or
- the practitioner is associated with an approved rural placement under Section 3GA of the Health Insurance Act 1973; or
- the practitioner has access to Medicare benefits as a result of the issue of a determination under Section 3J of the Health Insurance Act 1973 which only gives the practitioner access to Medicare benefits at specific practice locations; or
- the locum is to provide services at a practice which is participating in the Practice Incentives Program as the use of a provider number not specifically allocated for the practice will affect payments to the practice under the Practice Incentives Program.

2.3.2 Locums can direct Medicare payments to the principal of the practice by either arranging a pay group link and/or by nominating the principal as the payee on bulk bill stationery.

2.4 Approved Placement for Rural Locations (Section 3GA Approvals)

2.4.1 There are two categories of medical practitioner for whose services Medicare benefits are not payable. They are medical practitioners:-

- subject to the 10 year moratorium; and
- first registered on or after 1 November 1996 who are not eligible for recognition as either a general practitioner or specialist.

2.4.2 Arrangements exist to enable medical practitioners (otherwise ineligible to access Medicare) to do after hours work or rural locum work through a structure that provides adequate supervision, quality assurance and backup arrangements while allowing Medicare billing from an approved practice placement site.

2.4.3 Further information on approved placements for rural locums is available from the Department of Health and Ageing on (02) 6289 4203.

2.5 Overseas Trained Doctors and the Ten Year Moratorium

2.5.1 Section 19AB of the Health Insurance Act 1973 provides that services provided by overseas trained doctors (including New Zealand doctors) and overseas doctors trained in Australia will not attract Medicare benefits for a period of 10 years from the time they become registered as a medical practitioner for the purposes of the Health Insurance Act (the date from which the 10 year moratorium will commence varies from case to case). These measures do not apply to doctors who:-

- before 1 January 1997, registered with a State or Territory medical board (not including a person on a temporary resident visa) provided that they retained the continuous legal right to remain in Australia; or
- made an application to the Australian Medical Council (AMC) which was received before 1 January 1997, to undertake examinations, successful completion of which would ordinarily enable the person to become a medical practitioner (and was eligible to lodge an application with the AMC); or
- is a temporary resident doctor (including New Zealand doctors) with a determination under Section 3J of the Health Insurance Act 1973 while working in accord with that determination.

2.5.2 The Minister can grant an exemption to these requirements and can impose conditions on any exemption provided. Requests for exemption from the moratorium should be directed to the Department of Health and Ageing on (02) 6289 5903.

2.6 Temporary Resident Doctors (TRD) and Occupational Trainees (OT)

2.6.1 To be allocated a Medicare provider number a TRD/OT must be supported by their employer and be able to demonstrate that there is a need to have Medicare benefits payable for their services, refer or request specialist services for Medicare purposes and/or provide prescriptions under the Pharmaceutical Benefits Scheme. The following documentation is required with an application for a Medicare provider number:-

- Australian medical registration papers; and
- a copy of personal details in a passport and all Australian visas and entry stamps; and
- a letter from the employer stating the reason why a Medicare provider number and/or prescriber number is required; and
- a copy of the employment contract.

2.6.2 Those TRD/OT deemed eligible for a Medicare provider number by the issue of a Section 3J determination by the Minister's delegate will need to provide their name and address, as well as their Medicare provider number on all bills for services they have rendered where a Medicare benefit is to be claimed.

2.6.3 The issue of a 3J determination is not automatic and is not backdated. Medicare benefits cannot be paid for services rendered by a TRD/OT until a 3J determination has been issued. Delegations for the issue of 3J determinations are held by the Department of Health and Ageing and as a result, applications received by the Health Insurance Commission will be forwarded to the Department for approval. Applicants for 3J determinations should apply to the Health Insurance Commission.

2.6.4 TRD/OT are usually granted conditional medical registration. Use of a Medicare provider number outside of the conditions imposed through their visa and medical registration will make the TRD/OT liable to action by the Department of Immigration and Multicultural Affairs and the State or Territory medical board.

2.6.5 Information about applying for a Medicare provider number can be obtained by telephone on 132 150 (a local call cost) or by contacting the Provider Liaison Section of the Health Insurance Commission in your State.

2.7 Use of Provider Numbers and Closure of Practice Locations

2.7.1 Use of an incorrect Medicare provider number may be a breach of Health Insurance Regulations which require that an account/receipt lodged with a claim for Medicare benefits must contain the practitioner's name and either:-

- the address of the place from which the service was provided; OR
- the provider number for the place from which the service was provided.

2.7.2 It is important that the Health Insurance Commission be notified promptly where a practitioner ceases to practice from a location. Failure to notify closure can lead to misdirection of Medicare cheques and other information from the Health Insurance Commission.

2.8 Practice Incentives Program

2.8.1 Practitioners who work at practices participating in the Practice Incentives Program are reminded about the importance of having a provider number linked to that practice. Under the Practice Incentives Program, only services rendered by a practitioner with a provider number linked to the practice location will be taken into account when determining the practice's payment. Medicare and the Department of Veterans' Affairs data is used to identify consultations linked to provider numbers. Even practitioners working for limited periods at the practice should have a provider number allocated for that period.

2.9 Addresses of the Health Insurance Commission

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

Telephone: 132150, All States (a local call cost)

NEW SOUTH WALES

The Colonial State Bank
Tower
150 George Street
PARRAMATTA NSW 2165

VICTORIA

State Headquarters
460 Bourke Street
MELBOURNE VIC 3000

QUEENSLAND

State Headquarters
444 Queen Street
BRISBANE QLD 4000

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD SA 5063

WESTERN AUSTRALIA

State Headquarters
Bank West Tower
108 St. George's Terrace
PERTH WA 6000

TASMANIA

242 Liverpool Street
HOBART TAS 7000

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG ACT 2901

NORTHERN TERRITORY

As per South Australia

3. PATIENT ELIGIBILITY FOR MEDICARE**3.1 Eligible Persons**

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

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

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

3.2 Medicare Cards

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

3.2.2 Medicare cards issued with the word "VISITOR" and a date means that at the time the card was issued, Medicare eligibility was restricted. These cards are issued to persons including visitors who have been determined to be eligible and eligible persons awaiting permanent resident status.

3.2.3 Special Medicare cards are issued where appropriate to persons accessing out-of-hospital medical care under a Reciprocal Health Care Agreement (RHCA). These cards are similar to a resident Medicare card and include a "Valid to" date but are endorsed "Visitor RHCA". Persons covered by the New Zealand (for arrivals after 1 September 1999) and Ireland Agreements do not hold Medicare "Visitor RHCA" cards as they are not entitled to access out-of-hospital benefits.

3.3 Health Care Expenses Incurred Overseas

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

3.4 Visitors to Australia and Temporary Residents

3.4.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents and such persons should take out private health insurance. People visiting Australia specifically for medical or hospital treatment are not eligible for Medicare benefits. (See also Reciprocal Health Care Agreements.)

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

3.5 Reciprocal Health Care Agreements

3.5.1 Visitors from countries with which Australia has Reciprocal Health Care Agreements are eligible for benefits to the extent specified in the Agreement for immediately necessary medical care under the Medicare Program. Likewise, Australians visiting these countries are entitled to health care under their public health schemes. Agreements are currently in place with New Zealand, the United Kingdom, the Netherlands, Sweden, Finland, Italy, Malta and Ireland. It is anticipated that an Agreement with Norway, and possibly Denmark, will be operational by 2003 (Medicare will be able to advise the status of these Agreements). Visitors are eligible for benefits for the duration of their stay, except in the case of Italy and Malta, where benefits are for six months only. With the exception of New Zealand, the Agreements provide diplomats and their families with full Medicare cover for the term of their stay, which is not restricted to immediately necessary treatment.

3.5.2 The Agreements provide for immediately necessary medical treatment only, that is, treatment for any episode of ill-health which requires prompt medical attention. However, the Agreements with New Zealand (for those visitors arriving after 1 September 1999) and Ireland are restricted to public hospital care only. Persons covered by these two Agreements do not hold Medicare "Visitor RHCA" cards as they are not entitled to access out-of-hospital benefits.

3.5.3 The Agreements do not include pre-arranged or elective treatment, or treatment as a private patient in a public or private hospital.

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

3.6.1 From 1 February 1996, Medicare benefits are payable for medical expenses for professional services that are wholly covered by workers compensation or damages under a Commonwealth or State or Territory law.

3.6.2 The only exception to this is where a person has entered into a *reimbursement arrangement* with a compensation insurer. In such cases, a Medicare benefit is not payable. (A *reimbursement arrangement* is an agreement between a compensation claimant and the insurer stating that the medical expenses of the person will be paid by the insurer as and when they arise.)

3.6.3 The practitioner has the option to either bulk-bill Medicare or give the patient a private account as would normally occur with any other consultation.

3.6.4 There are arrangements in place to recover any Medicare benefits paid as a result of the injury once a settlement or judgement is made on the compensation claim. The recovery is done between the insurer or compensation payer, the compensable person and the Health Insurance Commission. These recovery arrangements do not impact on practitioners.

4. GENERAL PRACTICE

4.1 General Practice Items

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

Vocationally Registered under section 3F of the Health Insurance Act (see 4.3 below); or
a holder of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) who participates in, and meets the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Program; or
undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP, or undertaking an approved placement in general practice as part of some other training program recognised by the RACGP as being of an equivalent standard.

4.2 Fellows of the RACGP and Trainees in General Practice

4.2.1 A medical practitioner who is seeking recognition as a general practitioner, as a Fellow of the RACGP or as a general practice trainee should apply to the Manager, Health Programs Branch, Health Insurance Commission, at any of the Commission addresses listed in paragraph 2.9.

4.3 Vocational Registration of General Practitioners

Recognition Method

4.3.1 The criteria for registration as a vocationally registered general practitioner are certification from either:-
the Royal Australian College of General Practitioners (RACGP); or
a General Practice Recognition Eligibility Committee (GPREC); or
the General Practice Recognition Appeal Committee (GPRAC),

that the practitioner's medical practice is or will be within 28 days predominantly general practice, and
that the RACGP or the Eligibility Committee certifies that the practitioner is a Fellow of the RACGP; and
the RACGP certifies that the practitioner meets its minimum requirements for taking part in continuing medical education and quality assurance programs.

4.3.2 The GPRAC will hear appeals from medical practitioners who are refused certification by either the RACGP or a GPREC.

4.3.3 The only training and experience which the RACGP regards as appropriate for eligibility will be the attainment of Fellowship of the RACGP.

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

4.3.5 All enquiries concerning eligibility for registration should be directed to the RACGP at 52 Parramatta Road, Forest Lodge, NSW, 2037, or to the GPREC, Health Insurance Commission, PO Box 1001, Tuggeranong, ACT 2901.

How to Apply for Registration

4.3.6 To be listed on the register, application on the approved form must be made to the RACGP or a GPREC for certification of eligibility. The RACGP or the GPREC will notify the Health Insurance Commission of the eligibility status of the practitioner for inclusion on the VR register.

4.3.7 The RACGP and GPREC address for the purpose of submission of applications for registration as a vocationally registered general practitioner are:

The Secretary-General
The Royal Australian College of General Practitioners
52 Parramatta Road
FOREST LODGE NSW 2037

Secretary
General Practice Recognition Eligibility Committee
Health Insurance Commission
PO Box 1001
TUGGERANONG ACT 2901

4.3.8 Continued vocational registration is dependent upon involvement in appropriate Continuing Medical Education (CME) and Quality Assurance (QA) programs approved by the RACGP, and the practitioner continuing to be predominantly in general practice.

4.3.9 All enquiries regarding the QA and CME requirements should be directed to the RACGP at 52 Parramatta Road, Forest Lodge, NSW, 2037.

Removal from Vocational Register

4.3.10 A medical practitioner may at any time request the Managing Director of the Health Insurance Commission to remove his/her name from the Vocational Register of General Practitioners.

4.3.11 Provision also exists for removal of a medical practitioner from the Vocational Register where the RACGP or a GPREC is no longer satisfied that the practitioner should remain on the Register. Examples of reasons for which a practitioner might be removed are:-

- the practitioner's medical practice is no longer predominantly general practice;
- the RACGP's minimum requirements for involvement in continuing Medical Education and Quality Assurance programs have not been met by the practitioner.

4.3.12 Appeals against removal may be made to the GPRAC, at the Health Insurance Commission, PO Box 1001, Tuggeranong, ACT, 2901.

4.3.13 Practitioners removed from the register for any reason must make a formal application to re-enter the register.

5. RECOGNITION AS A SPECIALIST OR CONSULTANT PHYSICIAN

5.1 Recognition Method

5.1.1 A medical practitioner who, having made formal application and paid the prescribed fee, and who:-

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

may be recognised by the Minister as a specialist or consultant physician for the purposes of the Health Insurance Act.

5.1.2 A medical practitioner who:-

is training towards a fellowship of a specified specialist College;

should apply to the Manager, Health Programs Branch, Health Insurance Commission, at any of the Commission addresses listed in paragraph 2.9, to be recognised as a specialist or consultant physician trainee.

5.1.3 There is provision for appeal to a Specialist Recognition Appeal Committee by medical practitioners who have not been recommended for recognition as specialists or consultant physicians by a Specialist Recognition Advisory Committee. 5.1.4

Where a medical practitioner has been recognised as a specialist or consultant physician for the purposes of the Health Insurance Act, Medicare benefits are payable at the appropriate higher rate in respect of certain services rendered by the practitioner in the practice of the recognised specialty, provided (other than in the case of examination by specialist anaesthetists in preparation for anaesthesia - see paragraph 6.3.1) the patient has been referred in accordance with paragraph 6.

5.1.5 All enquiries concerning the recognition of specialists and consultant physicians or specialist and consultant physician trainees should be directed to the Provider Liaison Section, Health Insurance Commission, PO Box 9822 in your State capital city. ACT and NT enquiries should be directed to NSW. Telephone enquiries can be directed to 132150 for the cost of a local call.

5.2 Emergency Medicine

5.2.1 For these purposes the following will determine when a practitioner is acting within the speciality of emergency medicine:-

Where the patient is treated by the medical practitioner within 30 minutes of presentation, and that patient is:

- (a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
- (b) suffering from suspected acute organ or system failure; or
- (c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- (d) suffering from a drug overdose, toxic substance or toxin effect; or

- (e) experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- (f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- (g) suffering acute significant haemorrhage requiring urgent assessment and treatment; and
- (h) treated in, or via, a bona fide emergency department in a hospital.

5.2.2 Benefits are not payable where such services are rendered in the accident and emergency departments or outpatient departments of public hospitals.

6. REFERRAL OF PATIENTS TO SPECIALISTS OR CONSULTANT PHYSICIANS

6.1 Purpose

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

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

6.2 What is a Referral

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

6.2.2 Subject to the exceptions in paragraph 6.2.3 below, for a valid "referral" to take place:-

- (i) the referring practitioner must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist or consultant physician (but this does not necessarily mean an attendance on the occasion of the referral);
- (ii) the instrument of referral must be in writing by way of a letter or note to a specialist or to a consultant physician and must be signed and dated by the referring practitioner; and
- (iii) the specialist or consultant physician to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.

6.2.3 The exceptions to the requirements in paragraph 6.2.2 are that:-

- (a) sub-paragraphs (i), (ii) and (iii) do not apply to:
 - . an examination of a patient by a specialist anaesthetist in preparation for the administration of an anaesthetic (Item 17603);
- (b) sub-paragraphs (ii) and (iii) do not apply to:
 - . a referral generated within a hospital, in respect of a privately admitted patient for a service within that hospital, where the hospital records provide evidence of a referral (including the referring practitioner's signature); or
 - . an emergency situation where the referring practitioner or the specialist or the consultant physician was of the opinion that the service be rendered as quickly as possible; and
- (c) sub-paragraph (iii) does not apply to:
 - . instances where a written referral was completed by a referring practitioner but was lost, stolen or destroyed.

NOTE: *"For these purposes an emergency is a situation where the patient is treated by the medical practitioner within thirty minutes of presentation, and that patient is:-*

- (a) *at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or*
- (b) *suffering from suspected acute organ or system failure; or*
- (c) *suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or*
- (d) *suffering from drug overdose, toxic substance or toxin effect; or*
- (e) *experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or*
- (f) *suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or*
- (g) *suffering acute significant haemorrhage requiring urgent assessment and treatment."*

6.3 Examination by Specialist Anaesthetists

6.3.1 A referral letter or note is not required in the case of Item [17603](#) - Examination of a patient in preparation for the administration of an anaesthetic. However, for benefits to be payable at the specialist rate for consultations by specialist anaesthetists (other than for a pre-operative examination) a referral is required.

6.4 Who can Refer

6.4.1 The general practitioner is regarded as the primary source of referrals. Cross referrals between specialists and/or consultant physicians should usually occur in consultation with the patient's general practitioner. (See paragraph [6.6.1](#)).

6.4.2 Referrals are to be made as follows:-

- (a) to a recognised consultant physician -

- (i) by another medical practitioner; or
 - (ii) by an approved dental practitioner¹ (oral surgeon), where the referral arises out of a dental service;
- (b) to a recognised specialist -
- (i) by another medical practitioner; or
 - (ii) by a registered dental practitioner², where the referral arises out of a dental service; or
 - (iii) by a registered optometrist where the specialist is an ophthalmologist.
- See paragraph OB.1 for the definition of an approved dental practitioner.
A registered dental practitioner is a dentist registered with the State or Territory Dental Board of the State or Territory in which s/he practices. A registered dental practitioner may or may not be an approved dental practitioner.

6.5 Billing

Routine Referrals

6.5.1 In addition to the usual information required to be shown on accounts, receipts or assignment forms (see [paragraph 7](#) of these notes), specialists and consultant physicians must show the following details (unless there are special circumstances as indicated in paragraph 6.5.2):-

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

Special Circumstances

6.5.2 (i) Lost, stolen or destroyed referrals.

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

(ii) Emergency situations - (see note at paragraph [6.2.3](#) for definition of an emergency situation).

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

(iii) Hospital referrals.

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

- Public Hospital Patients - Under the 1998-2003 Australian Health Care Agreements, hospitals are obliged to provide public hospital services to eligible persons in accordance with the provisions of the Agreements.

Bulk Billing

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

6.6 Period for which Referral is Valid

Specialist Referrals

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

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

Referrals by other Practitioners

6.6.3 Where the referral originates from a practitioner other than those listed in 6.6.1, the referral is valid for a period of 12 months, unless the referring practitioner indicates that the referral is for a period more or less than 12 months (eg. 3, 6 or 18 months or valid indefinitely). Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions.

6.6.4 The referral is valid for the period specified in the referral which is taken to commence on the date of the specialist's or consultant physician's first service covered by that referral.

6.7 Definition of a Single Course of Treatment

6.7.1 A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner. It also includes any subsequent review of the patient's condition by the specialist or the consultant physician that may be necessary.

Such a review may be initiated by either the referring practitioner or the specialist/consultant physician.

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

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

6.7.4 However, where the referring practitioner:-

- (a) deems it necessary for the patient's condition to be reviewed; and
- (b) the patient is seen by the specialist or the consultant physician outside the currency of the last referral; and
- (c) the patient was last seen by the specialist or the consultant physician more than 9 months earlier

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

6.8 Retention of Referral Letters

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

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

6.8.3 A specialist or a consultant physician is required, if requested by the Managing Director of the Health Insurance Commission, to produce to a Medical Adviser, who is an officer of the Commission, the instrument of referral within seven days after the request is received. Where the referral originates in an emergency situation or in a hospital, the specialist or consultant physician is required to produce such information as is in his or her possession or control relating to whether the patient was so treated.

6.9 Attendance for Issuing of a Referral

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

6.10 Locum-tenens Arrangements

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

6.10.2 Medicare benefits are not payable where a practitioner is not eligible to provide services attracting Medicare benefits acts as a locum-tenens for any practitioner who is eligible to provide services attracting Medicare benefits.

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

6.11 Self Referral

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

6.12 Referrals by Dentists or Optometrists

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

- (i) a recognised specialist:
 - (a) by a registered dental practitioner, where the referral arises out of a dental service; or
 - (b) by a registered optometrist where the specialist is an ophthalmologist; or

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

6.12.2 In any other circumstances (ie a referral to a consultant physician by a dentist, other than an approved oral surgeon, or an optometrist, or a referral by an optometrist to a specialist other than a specialist ophthalmologist), it is not a valid referral.

Any resulting consultant physician or specialist attendances will attract Medicare benefits at unreferred rates.

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

7. BILLING PROCEDURES

7.1 Itemised Accounts

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

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

- (i) patient's name;
- (ii) the date on which the professional service was rendered;
- (iii) a description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment (i.e., accommodation and nursing care) is provided in a hospital or day hospital facility (other than a public hospital patient), that is, the words 'admitted patient' immediately preceding the description of the service or an asterisk '*' directly after an item number where used;
- (iv) the name and practice address or name and provider number of the practitioner who actually rendered the service; (where the practitioner has more than one practice location recorded with the Health Insurance Commission, the provider number used should be that which is applicable to the practice location at or from which the service was given);
- (v) the name and practice address or name and provider number of the practitioner claiming or receiving payment of benefits, or assignment of benefit:-
 - for services in Groups [A1](#) to [A14](#), [D1](#), [T1](#), [T4](#) to [T9](#) of the General Medical Services, Groups [O1](#) to [O7](#) (Oral and Maxillofacial services), and Group [P9](#) of Pathology - where the person claiming payment is NOT the person who rendered the service;
 - for services in Groups [D2](#), [T2](#), [T3](#), [I2](#), to [I5](#) - for every service;
- (vi) if the service was a Specified Simple Basic Pathology Test (listed in Category 6 - Pathology, Group [P9](#) of the Schedule) that was determined necessary by a practitioner who is another member of the same group medical practice, the surname and initials of that other practitioner;
- (vii) where a practitioner has attended the patient on more than one occasion on the same day and on each occasion rendered a professional service to which an item in Category 1 of the Medicare Benefits Schedule relates (i.e. professional attendances), the time at which each such attendance commenced; and
- (viii) where the professional service was rendered by a consultant physician or a specialist in the practice of his/her speciality to a patient who has been referred:- (a) the name of the referring medical practitioner; (b) the address of the place of practice or provider number in respect of that place of practice; (c) the date of the referral; and (d) the period of referral (where other than for 12 months) expressed in months, e.g. "3", "6" or "18" months, or "indefinitely".

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

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

7.2 Claiming of Benefits

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

7.3 Paid Accounts

7.3.1 The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.

7.3.2 In these circumstances, where a claimant personally attends a Medicare office to obtain a cash or EFT for the payment of Medicare benefits, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

7.3.3 A Medicare patient claim form (PC1) is required to be completed where the claimant is mailing their claim for a cheque or EFT payment of Medicare benefits or arranging for an agent to collect cash on the claimant's behalf at a Medicare office.

7.4 Unpaid Accounts

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

7.4.2 It will be the patient's responsibility to forward the cheque to the doctor and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits, by law, must not be sent direct to medical practitioners or to patients at a doctor's address (even if requested by the claimant to do so). "Pay doctor" cheques are required to be forwarded to the claimant's last known address.

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

7.5 Assignment of Benefit (Bulk - Billing) Arrangements

7.5.1 Under the Health Insurance Act an Assignment of Benefit (bulk-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.

7.5.2 If a medical practitioner bulk-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient, with the exception of certain vaccines (see paragraph 7.5.4).

7.5.3 Under these arrangements:-

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

7.5.4 Where the patient is bulk-billed, an additional charge can **ONLY** be raised against the patient by the practitioner where the patient is provided with a vaccine/vaccines from the practitioner's own supply held on the practitioner's premises. This exemption only applies to general practitioners and other non-specialist practitioners in association with attendance items 3 to 96 (inclusive) and only relates to vaccines that are not available to the patient free of charge through Commonwealth or State funding arrangements or available through the Pharmaceutical Benefits Scheme. The additional charge must only be to cover the supply of the vaccine.

7.6 Use of Medicare Cards in Bulk Billing

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

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

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

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

7.6.5 It is important for the practitioner to check the eligibility of patients to Medicare benefits by reference to the card, as enrollees have entitlement limited to the date shown on the card and some enrollees, e.g. certain visitors to Australia, have restricted access to Medicare (see paragraphs 3.4 and 3.5).

7.7 Assignment of Benefit Forms

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

- (1) Form DB2-GP. This form is designed for the use of optical scanning equipment and is used to assign benefits for General Practitioner Services other than requested pathology, specialist and optometrical services. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Practitioner copy and a Patient copy. There are 4 pre-printed items with provision for two other items. The form can also be used as an "offer to assign" when a request for pathology services is sent to an approved pathology practitioner and the patient does not attend the laboratory.
- (2) Form DB2-OP. This form is designed for the use of optical scanning equipment and is used to assign benefits for optometrical services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. This form may not be used as an offer to assign pathology services.
- (3) Form DB2-OT. This form is designed for the use of optical scanning equipment and is used to assign benefits for all specialist services. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2-GP, except for content variations. There are no pre-printed items on this form.
- (4) Form DB3. This is used to assign or offer to assign benefits for pathology tests rendered by approved pathology practitioners. It is loose leaf to enable imprinting of patient details from the Medicare card and is similar in most respects to Form DB2, except for content variations. The form may not be used for services other than pathology.
- (5) Form DB4. This is a continuous stationery version of the DB2, and has been designed for use on most office accounting machines.
- (6) Form DB5. This is a continuous stationery form for pathology services which can be used on most office machines. It cannot be used to assign benefits and must therefore be accompanied by an offer to assign (Form DB2, DB3 or DB4) or other form approved by the Health Insurance Commission for that purpose.

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

7.8.1 Practitioners who accept assigned benefits must claim from Medicare using either Claim for Assigned Benefits form DB1 or DB1H. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than public patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal doctor and setting the locum up with a provider number and pay-group link for the principal doctor's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

7.8.2 Each claim form must be accompanied by the assignment forms to which the claim relates.

7.8.3 The DB1 and DB1H are also loose leaf to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards, showing the practitioner's name, practice address and provider number are available from Medicare on request.

7.9 Bulk-Bill Stationery

7.9.1 Medical practitioners wishing to bulk-bill may obtain information on bulk-bill stationery by telephoning 132150.

Form DB6A. This form is used to order stocks of forms DB3, DB4 and DB5 and where a practitioner uses these forms, DB1 and DB1H. These forms are available from Medicare.

Form DB6B. This form is used to re-order kits for optical scanning stationery which comprise DB2's (GP, OP and OT), DB1's pre addressed envelopes and an instruction sheet for the use of bulk-bill scanning stationery. The scanning stationery is only available in kit form. This form is supplied with the kit and is returned directly to the printer. Medicare is unable to provide information on the status of these orders.

7.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

7.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the bulk-billing (assignment of benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.

7.10.2 Provision exists whereby in certain circumstances (eg hardship cases, third party workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

8. PROVISION FOR REVIEW OF INDIVIDUAL DOCTORS, INDIVIDUAL CLAIMS AND SCHEDULE SERVICES

Doctors

8.1 Professional Services Review (PSR) Scheme

8.1.1 The Professional Services Review (PSR) Scheme provides for a system of peer review to determine whether a practitioner has inappropriately rendered or initiated services which attract a Medicare benefit, or has inappropriately prescribed under the Pharmaceutical Benefits Scheme (PBS).

8.1.2 Section 82 of the *Health Insurance Act 1973* defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.

8.1.3 A PSR Committee will normally consist of three medically qualified members of whom two must belong to the same profession as the practitioner whose conduct is the subject of review. However, if considered desirable, up to two additional members may be appointed to a Committee to give it a wider range of clinical expertise.

8.1.4 From 1 August 1999, changes were introduced to improve the administration of the PSR Scheme. These include increased investigation, case preparation and negotiation powers for the Director of PSR and greater legal support for the person under review. The PSR Tribunals have also been removed from the process whilst retaining the right of review on points of law.

8.1.5 Under the PSR Scheme, the decision to establish a PSR Committee is made by the independent Director of PSR after receiving an investigative referral for the review of a practitioner's conduct from the Health Insurance Commission.

8.1.6 When an investigative referral is made, the Director of PSR must conduct an investigation, in such manner as he or she thinks appropriate, into the referred services, including services not dealt with in reasons given by the Commission for the referral. The Director has the power to require the production of documents or the giving of information.

8.1.7 The Director also has the power to dismiss an investigative referral, set up a PSR Committee, negotiate a written agreement with the practitioner, or take no action.

8.1.8 The various methods available to a PSR Committee to investigate and quantify inappropriate practice have been clarified. In addition to examining identified services, the legislation now provides for the following methodologies:

Patterns of Services - Where a practitioner reaches or exceeds a volume of services specified in regulations, he or she is deemed to have practised inappropriately. From 1 January 2000, the pattern of services for general practitioners and other medical practitioners specified in the Health Insurance Amendment Regulations 1999 (No. 1) is 80 or more professional attendances on each of 20 or more days in a 12-month period.

A professional attendance is defined as a service of a kind mentioned in group [A1](#), [A2](#), [A5](#), [A6](#), [A7](#), [A13](#), [A14](#) or [A15](#) of Part 2 of the General Medical Services Table.

The quantum of inappropriate practice can be reduced if the practitioner can demonstrate exceptional circumstances to the satisfaction of a PSR Committee. Matters that constitute exceptional circumstances include, but are not limited to, those set out in the Regulations. Matters constituting exceptional circumstances, as set out in the regulations, are: an unusual occurrence causing an unusual level of need for professional attendances by the practitioner; and the absence of other medical services for the practitioner's patients (having regard to the location of the practice and the characteristics of the patients).

Where a practitioner can demonstrate to the satisfaction of a PSR Committee that exceptional circumstances exist, the quantum of inappropriate practice is reduced accordingly. For example, a general practitioner is referred to a PSR Committee for rendering more than 80 services on 28 days in a 12-month period. The practitioner demonstrates to the PSR Committee that exceptional circumstances applied on 10 of those days. The practitioner would still be found to have engaged in inappropriate practice in respect of the remaining 18 days.

Sampling - A PSR Committee can apply a statistically valid sampling methodology to examine the conduct of a practitioner in relation to particular identifiable services and to extrapolate the results to a larger number of similar services within the referral period.

Generic findings - If a PSR Committee cannot conduct its inquiry using the patterns of services or sampling provisions, it can make a generic finding of inappropriate practice. This will apply where a PSR Committee is unable to obtain sufficient clinical or practice records from the practitioner to conduct its investigation.

8.1.9 In determining whether a practitioner has engaged in inappropriate practice, from 1 November 1999 a PSR Committee is also required to have regard to whether or not the practitioner kept adequate and contemporaneous patient records (see details at Note 15.).

8.1.10 The new PSR arrangements apply in relation to new cases referred by the HIC to the Director of PSR after 1 August 1999. Existing cases will be dealt with under the previous arrangements.

8.2 Medicare Participation Review Committee (MPRC)

8.2.1 The Medicare Participation Review Committee determine what administrative action should be taken against a practitioner who has been successfully prosecuted for medifraud.

8.2.2 The Committees have a discretionary range of options from taking no further administrative action against the practitioner to counselling and reprimand and full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

Schedule Services

8.3 Medicare Benefits Consultative Committee (MBCC)

8.3.1 The MBCC is an informal advisory committee established by agreement between the Minister and the Australian Medical Association. The Committee consists of representatives of the Department, the Health Insurance Commission, the Australian Medical Association and relevant craft groups of the medical profession.

8.3.2 The major function undertaken by the Committee is the review of particular services or groups of services within the Medicare Benefits Schedule, including consideration of appropriate fee levels.

8.4 Medical Services Advisory Committee (MSAC)

8.4.1 The Medical Services Advisory Committee was established in April 1998 to advise the Minister on the strength of evidence relating to the safety, effectiveness and cost effectiveness of new and emerging medical services and technologies and under what circumstances public funding, including listing on the Medicare Benefits Schedule, should be supported.

8.4.2 Its membership comprises a mix of clinical expertise covering pathology, surgery, internal medicine and general practice, plus clinical epidemiology and clinical trials, health economics, consumers, and health administration and planning. 8.4.3 The assessment of evidence has been an integral part of the listing process of medical technologies and services on the Schedule via a mix of specialist consultative and advisory bodies. This measure will strengthen and consolidate the assessment activity under the umbrella of MSAC and will complement the functions and activities of the Medicare Benefits Consultative Committee, Pathology Services Table Committee and the Consultative Committee on Diagnostic Imaging.

8.4.4 Since its establishment MSAC has been developing application and assessment guidelines to assist it to meet its terms of reference. Further information on MSAC's terms of reference, membership, and application and assessment processes and related activities can be found at its internet site www.health.gov.au/msac/index.htm

8.4.5 Contact with MSAC can be made via email on msac.secretariat@health.gov.au or by phoning the MSAC secretariat on 1800 020 103.

8.5 Pathology Services Table Committee (PSTC)

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

8.5.2 The Committee's primary role is to advise the Minister on the need for changes to the structure and content of the Pathology Services Table (except new medical services and technologies - see paragraph 8.5 above) including the level of fees.

8.6 Review of Claims Requiring Prior Approval for Payment of Benefits

8.6.1 There are a number of items in the Schedule which contain a requirement that it must be 'demonstrated' that there is a clinical need for the service before Medicare benefits are payable. Services requiring prior approval are those covered by Items [11222/11225](#), [12207](#), [14120-14132](#), [30214](#), [32501](#), [42783](#), [42786](#), [42789](#), [42792](#), [45019/45020](#), [45528](#), [45557](#), [45558](#), [45585](#), [45588](#), [45639](#), [50125](#) and [55728](#).

8.6.2 Claims for benefits for services covered by these items should be lodged with Medicare for referral to the National Office of the Health Insurance Commission for assessment by the Medicare Claims Review Panel (MCRP) and must be accompanied by sufficient clinical and/or photographic evidence to enable the Commission to determine the eligibility of the service for payment of benefits. Claims can only be considered for services which fulfil the requirements of the item descriptors.

8.6.3 Practitioners may also apply to the Commission for prospective approval in respect of proposed surgery.

8.6.4 Applications for approval should be addressed to 'The MCRP Officer, PO Box 1001, Tuggeranong ACT 2901'.

9. PENALTIES AND LIABILITIES

9.1 Penalties

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

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

GENERAL NOTES FOR GUIDANCE OF USERS

10. SCHEDULE FEES AND MEDICARE BENEFITS

10.1 Schedule Fees and Medicare Benefits

10.1.1 Medicare benefits are based on fees determined for each medical service, with uniform fees for each service in each State. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered. In some cases two levels of fees are applied to the same service in General Medical Services, with each level of fee being allocated a separate item number. The item identified by the letter "S" applies in the case where the procedure has been rendered by a recognised specialist in the practice of his or her speciality and the patient has been referred. The item identified by the letter "G" applies in any other circumstances.

10.1.2 As a general rule Schedule fees are adjusted on an annual basis. The current Schedule fees came into operation on 1 November 2002.

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

There are presently two levels of Medicare benefit payable, that is :-

- (i) for professional services rendered while hospital treatment (ie accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), the level of Medicare benefit is 75% of the Schedule fee for each item with no maximum patient gap between the Medicare benefit and the Schedule fee. The Health Insurance Regulations provide that medical practitioners must indicate on their accounts, etc, where a medical service is rendered in these circumstances. This requirement will be met by placing the word "admitted patient" immediately preceding the description of each service or, alternatively, where an item number is used, by placing an asterisk "*" directly after the item number for each service.
- (ii) for all other professional services, the Medicare benefit is 85% of the Schedule fee, or the Schedule fee less \$57.10 (indexed annually) whichever is the greater.

10.1.4 Public hospital services are available free of charge to eligible persons who choose to be treated as public patients, in accordance with the provisions of the 1998-2003 Australian Health Care Agreements.

10.1.5 A medical service rendered to a patient on the day of admission to, or day of discharge from hospital, but prior to admission or subsequent to discharge, will attract benefits at the 85% level not 75%. This also applies to a pathology service rendered to a patient prior to admission. Attendances on patients at a hospital (other than patients covered by para 10.1.3 (i) above) attract benefits at the 85% level.

10.1.6 The 75% benefit level applies even though a portion of the service (eg. aftercare) may be rendered outside the hospital. With regard to obstetric items, benefits would be attracted at the 75% level where the confinement takes place in hospital.

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

10.1.8 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (i.e., the difference between the Medicare rebate and the Schedule fee) for services attracting benefits at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefits and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an arrangement with their health fund.

10.1.9 Where it can be established that payments of \$309.80 (indexed annually from 1 January) have been made by a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for out-of-hospital services, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee.

11. SERVICES NOT LISTED IN THE SCHEDULE

11.1 Services not Listed in Schedule

11.1.1 Benefits are not generally payable for services not listed in the Schedule. However, there are some procedural services which are not specifically listed because they are regarded as forming part of a consultation or else attract benefits on an attendance basis. Such services would include intramuscular injections, aspiration needle biopsy, treatment of solar keratoses and closed reduction of toe fracture. Further services for which benefits are payable on a consultation basis are identified in the indexes to this book.

11.1.2 Enquiries concerning services not listed or on matters of interpretation should be directed to the appropriate office of the Health Insurance Commission. Postal addresses are listed in paragraph 2.9 of these notes. Telephone enquiries should be directed to the numbers below which are reserved for enquiries concerning the Schedule:

NSW -	132 150
VIC -	03 9605 7964
QLD -	07 3004 5280
SA -	08 8274 9788
NT -	08 8274 9788
WA -	132 150
TAS -	03 6215 5740
ACT -	02 6124 7611

11.2 Ministerial Determinations

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

12. SERVICES ATTRACTING MEDICARE BENEFITS

12.1 Professional Services

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

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

- (a) All Category 1 (Professional Attendances) items (except 170-172, 342-346);
- (b) Each of the following items in Group [D1](#) (Miscellaneous Diagnostic):- [11012](#), [11015](#), [11018](#), [11021](#), [11212](#), [11304](#), [11500](#), [11600](#), [11601](#), [11627](#), [11701](#), [11712](#), [11724](#), [11921](#), [12000](#), [12003](#);
- (c) All Group [T1](#) (Miscellaneous Therapeutic) items (except [13020](#), [13025](#), [13200-13206](#), [13212-13221](#), [13703](#), [13706](#), [13709](#), [13750-13760](#), [13915-13948](#), [14050](#), [14053](#), [14218](#) and [14221](#));
- (d) Item [15600](#) in Group [T2](#) (Radiation Oncology);
- (e) All Group [T3](#) (Therapeutic Nuclear Medicine) items;
- (f) All Group [T4](#) (Obstetrics) items (except [16514](#));
- (g) All Group [T6](#) (Anaesthetics) items;
- (h) All Group [T7](#) (Regional or Field Nerve Block) items;
- (i) All Group [T8](#) (Operations) items;
- (j) All Group [T9](#) (Assistance at Operations) items.

12.1.3 For the group psychotherapy and family group therapy services covered by Items [170](#), [171](#), [172](#), [342](#), [344](#) and [346](#), benefits are payable only if the services have been conducted personally by the medical practitioner.

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

12.2 Services Rendered "On Behalf Of" Medical Practitioners

12.2.1 Medical services in Categories [2](#) and [3](#) not included in the above list and Category [5](#) (Diagnostic Imaging) services continue to attract Medicare benefits if the service is rendered by:-

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

(see Category [6](#) Notes for Guidance for arrangements relating to Pathology services).

12.2.2 In order that a service rendered by an employee or under the supervision of a medical practitioner can attract a Medicare rebate, the service must be billed in the name of the practitioner who must accept full responsibility for the service. The Health Insurance Commission would need to be satisfied with the employment and supervision arrangements. In this regard, while the supervising medical practitioner need not be present for the entire service, he or she must have a direct involvement in at least part of the service. Although the supervision requirements would vary depending on the test or examination being performed, they would, as a general rule, be satisfied where the medical practitioner has:-

- (i) established consistent quality assurance procedures for the data acquisition; and

- (ii) personally analysed the data and written the report.

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

13. SERVICES WHICH DO NOT ATTRACT MEDICARE BENEFITS

13.1 Services Not Attracting Benefits

13.1.1 Medicare benefits are not payable for telephone consultations, for the issue of repeat prescriptions when the patient is not in attendance, and for group attendances (other than group attendances covered by Items [170](#), [171](#), [172](#), [342](#), [344](#) and [346](#)) such as counselling, health education, weight reduction or fitness.

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

13.1.3 Medicare benefits are not payable for the performance of euthanasia, including any service directly related to the procedure. However, services rendered for counselling/assessment in relation to euthanasia would attract benefits.

13.2 Where Medicare Benefits are not Payable

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

- (a) where the medical expenses for the service are paid or payable to a recognised (public) hospital;
- (b) where the medical expenses for the services are in relation to a compensable injury or illness for which the patient's insurer or compensation payer has accepted liability. However, if medical expenses relate to a compensable injury or illness and the insurer or compensation payer is disputing liability, Medicare benefits are payable until liability is accepted;
- (c) where the service is a medical examination for the purposes of - life insurance, superannuation or provident account scheme, or admission to membership of a friendly society;
- (d) where the service was rendered in the course of the carrying out of mass immunisation. 13.2.2

Unless the Minister otherwise directs, Medicare benefits are not payable in respect of a professional service where:-

- (a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory;
- (b) the medical expenses were incurred by the employer of the person to whom the service was rendered;
- (c) the person to whom that service was rendered was employed in an industrial undertaking and that service was rendered to him/her for purposes connected with the operation of that undertaking; or
- (d) the service was a health screening service (see para 13.3 below).

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

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

- (a) professional services rendered in relation to the provision of chelation therapy (that is to say the intravenous administration of ethylenediamine tetra-acetic acid or any of its salts) otherwise than for the treatment of heavy-metal poisoning;
- (b) professional services rendered in association with the injection of human chorionic gonadotrophin in the management of obesity;
- (c) professional services rendered in relation to the use of hyperbaric oxygen therapy in the treatment of multiple sclerosis;
- (d) professional services rendered for the purpose of, or in relation to, the removal of tattoos; and
- (e) professional services rendered for the purposes of, or in relation to:-
 - (i) the transplantation of a thoracic or abdominal organ, other than a kidney, or of a part of an organ of that kind; or
 - (ii) the transplantation of a kidney in conjunction with the transplantation of a thoracic or other abdominal organ, or part of an organ of that kind;if the services are rendered to an admitted patient of a hospital;
- (f) professional services rendered for the purposes of, or in relation to, the removal from a cadaver of kidneys for transplantation;
- (g) professional services rendered in respect of body fluids in relation to detection of the presence of the human immunodeficiency virus.

13.3 Health Screening Services

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

13.3.2 A health screening service is defined as a medical examination or test that is not reasonably required for the management of the medical condition of the patient. Services covered by this proscription include such items as - multiphasic health screening; mammography screening (except as provided for in Items [59300/59303](#)); testing of fitness to

undergo physical training programs, vocational activities or weight reduction programs; compulsory examinations and tests to obtain a flying, commercial driving or other licence, entrance to schools and other educational facilities, for travel requirements and for the purposes of legal proceedings; compulsory examinations for admission to aged persons' accommodation and pathology services associated with clinical ecology.

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

- a medical examination or a test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain his/her state of health. In such cases benefits would be payable for the attendance and such tests which would be considered reasonably necessary according to the circumstances of the patient such as age, physical condition, past personal and family history. Examples would be Papanicolaou test in a woman (see para. 13.3.4), blood lipid estimation where a person has a family history of lipid disorder. However, it would not be accepted that a routine check up would necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- medical examinations for reason of age or medical condition, for drivers to obtain or renew a licence to drive a private motor vehicle;
- medical examinations to obtain a certificate of hearing disability required for sales tax exemption for a television decoding device;
- a medical or optometrical examination provided to a person who is an unemployed person for the purposes of the Social Security Act 1991, at the request of a person to whom the unemployed person has applied for employment;

- a medical examination of, and/or the collection of blood for testing from, persons occupationally exposed to sexual transmission of disease where the purpose of such an examination or collection is the collection of specimens for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed, (1 examination/collection per person per week). Benefits are not attracted in respect of pathology tests resulting from such examination/collection;
- a medical examination to adopt or foster children;
- a medical examination which is required to claim eligibility for certain Social Security benefits or allowances.

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

- an examination interval of 2 years for women who have no symptoms or history suggestive of abnormal cervical cytology, commencing between the ages of 18 to 20 years, or 1 or 2 years after first sexual intercourse, whichever is later;
- cessation of cervical smears at 70 years for women who have had 2 normal results within the last 5 years. Women over 70 who have never been examined, or who request a cervical smear, should be examined.

Note 1: As separate items exist for routine examination of cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, if the smear has been taken as a routine examination or for the management of a previously detected abnormality (see paragraph [PP.4](#) of Pathology Services Explanatory Notes in Category 6).

Note 2: See items [2501](#), [2503](#), [2504](#), [2506](#), [2507](#), [2509](#), and [2600](#), [2603](#), [2606](#), [2610](#), [2613](#) and [2616](#) in Group [A18](#) and [A19](#) of Category [1](#) - Professional Attendances and [A.27](#) in the explanatory notes for Category [1](#) - Professional Attendances.

13.4 Services Rendered to a Doctor's Dependants, Practice Partner, or Practice Partner's Dependants

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

14. INTERPRETATION OF THE SCHEDULE - GENERAL NOTES

14.1 Principles of Interpretation

14.1.1 Each professional service listed in the Schedule is a complete medical service in itself. However, it may also form part of a more comprehensive service covered by another item, in which case the benefit provided for the latter service covers the former as well. For example, benefit is not payable for a bronchoscopy (Schedule Item [41889](#)) where a foreign body is removed from the bronchus (Schedule Item [41895](#)) since the bronchoscopy is an integral part of the removal operation. 14.1.2 Where a service is rendered partly by one medical practitioner and partly by another, only the one amount of benefit is payable. This may be instanced by the case in which a radiographic examination is partly completed by one medical practitioner and finalised by another, the only benefit payable being that for the total examination. Another example is where aftercare is carried out by other than the practitioner who performed the operation. The fee for the operation also covers any

consequential aftercare and only the one benefit is payable. Where separate services covered by individual items in the Schedule are rendered by different medical practitioners the individual items apply.

14.2 Services Attracting Benefits on an Attendance Basis

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

14.3 Consultation and Procedures Rendered at the One Attendance

14.3.1 Where there are rendered, during the course of a single attendance, a consultation (under Category 1 of the Medicare Benefits Schedule) and another medical service (under any other Category of the Schedule), benefits are payable subject to certain exceptions, for both the consultation and the other service. Medicare benefits are not payable for the consultation in addition to an item rendered on the same occasion where the item description is qualified by words such as "each attendance", "attendance at which", "including associated attendances/consultations", and all items in Group T6 and T9. However, in the case of radiotherapy treatment (Group T2 of Category 3) benefits are payable for both the radiotherapy and an initial referred consultation.

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

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

14.4 Aggregate Items

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

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

14.5 Residential Aged Care Facility

14.5.1 A residential aged care facility is a facility in which residential care services are provided, as defined in the *Aged Care Act 1997*, including facilities which were formerly known as nursing homes and hostels.

15. PRACTITIONERS SHOULD MAINTAIN ADEQUATE AND CONTEMPORANEOUS RECORDS FROM 1 NOVEMBER 1999

15.1 Requirements

15.1.1 All practitioners who provide, or initiate, a service in respect of which a Medicare benefit is payable, should ensure they maintain adequate and contemporaneous records. (Note: 'Practitioner' is defined in Section 81 of the *Health Insurance Act 1973* and includes: dentists, optometrists, chiropractors, physiotherapists and podiatrists.)

15.1.2 From 1 November 1999 PSR Committees will have regard to whether or not the practitioner kept adequate and contemporaneous records when determining whether a practitioner has engaged in inappropriate practice.

15.1.3 The standards which a record must meet to constitute an adequate and contemporaneous patient or clinical record are prescribed in regulations.

15.1.4 To be **adequate**, the patient or clinical record should be:

- sufficient to contribute to the quality and continuity of care received by the patient (*The record of a single visit may be quite brief. However, where a patient has made several visits to the same practice - even for simple conditions - then a more complete patient history would be expected.*);
- sufficiently clear and detailed, so that another practitioner can safely and effectively undertake the patient's ongoing care on the basis of the information contained in the record (*The record must be understandable by other practitioners. Note, this does not preclude the use of diagrams.*); and
- capable of identifying the service that was provided, or initiated. (*Sufficient clinical information must be recorded to justify the service rendered.*)

15.1.5 To be **contemporaneous**, the patient or clinical record should be completed at the time that the service was provided or as soon as practicable afterwards. Records for hospital patients are usually kept by the hospital and the practitioner could rely on these records to document in-patient care.

15.1.6 It will be left to the peer judgment of the PSR Committee to decide if the practitioner's records meet the prescribed standards. The failure to keep adequate records will be an important consideration for a PSR Committee in determining whether a practitioner's conduct was inappropriate (see paragraph [8.1.9](#)).



GENERAL MEDICAL SERVICES

CATEGORIES 1, 2 and 3



PROFESSIONAL ATTENDANCES

CATEGORY 1



CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

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CATEGORY 1 - PROFESSIONAL ATTENDANCES

EXPLANATORY NOTES

A.1 Personal Attendance by Practitioner

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

A.2 Professional Attendances

A.2.1 Professional attendances by medical practitioners cover consultations during which the practitioner evaluates the patient's problem (which may include certain health screening services - see paragraph [13.3](#) of the General Explanatory Notes) and formulates a management plan, in relation to one or more conditions present in the patient. The service also includes advice to the patient and/or relatives and the recording of appropriate detail of the particular services - (see also paragraphs A.5.6 - A.5.7)

A.3 Services Not Attracting Medicare Benefits

A.3.1 Telephone consultations, letters of advice by medical practitioners, the issue of repeat prescriptions when the patient is not in attendance, post mortem examinations, the issue of death or cremation certificates, counselling of relatives (Note - Items [348](#), [350](#) and [352](#) are not counselling services), group attendances (other than group attendances covered by Items [170](#), [171](#), [172](#), [342](#), [344](#) and [346](#)) such as group counselling, health education, weight reduction or fitness classes do not qualify for benefit.

A.4 Multiple Attendances

A.4.1 Payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner provided the subsequent attendances are not a continuation of the initial or earlier attendances.

A.4.2 However, there should be a reasonable lapse of time between such attendances before they can be regarded as separate attendances.

A.4.3 Where two or more attendances are made on the one day by the same medical practitioner the time of each attendance should be stated on the account (eg 10.30 a.m. and 3.15 pm) in order to assist in the assessment of benefits.

A.4.4 In some circumstances a subsequent attendance on the same day does in fact constitute a continuation of an earlier attendance. For example, a preliminary eye examination may be concluded with the instillation of a mydriatic and then an hour or so later eye refraction is undertaken. These sessions are regarded as being one attendance for benefit purposes. Further examples are the case of skin sensitivity testing, and the situation where a patient is issued a prescription for a vaccine and subsequently returns to the surgery for the injection.

A.5 Attendances by General Practitioners (Items [1-51](#), [193](#), [195](#), [601](#), [602](#), [2501](#) - [2559](#))

A.5.1 Items [1](#) to [51](#) and [193](#), [195](#), [601](#), [602](#), [2501](#) - [2559](#) relate specifically to attendances rendered by medical practitioners who are either:

- . listed on the Vocational Register of General Practitioners maintained by the Health Insurance Commission;
- . holders of the Fellowship of the Royal Australian College of General Practitioners (FRACGP) and who participate in, and meet the requirements for, quality assurance and continuing medical education as defined in the RACGP Quality Assurance and Continuing Education Programme; or
- . undertaking an approved placement in general practice as part of a training program for general practice leading to the award of the FRACGP or recognised by the RACGP as being at an equivalent standard.

Only general practitioners are eligible to itemise these content-based items. (See paragraphs 4.1, 4.2 and 4.3 of the General Explanatory Notes for details of eligibility and registration).

A.5.2 Items [1](#) to [51](#) cover four categories of general practitioner attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

A.5.3 The attendances are divided into four categories relating to the level of complexity.

A.5.4 To assist medical practitioners in selecting the appropriate item number for Medicare benefit purposes the following notes and examples in respect of the various levels are given. The fact that a particular case is used as an example does not mean that such cases would always be claimed at the level used in the example. Other modifying circumstances might prevail and each case must be treated on its merits.

LEVEL A

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

Example: Triple Antigen or Tetanus Immunisation

LEVEL B

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

Example: Otitis media presenting as earache

LEVEL C

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

Example: Essential hypertension presenting as headache

LEVEL D

These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level D attendance.

Examples: Migraine with peripheral neurological signs Depression
 presenting as insomnia or headaches Complex psychological
 or family relationship problems

Counselling or Advice to Patients or Relatives A.5.5

For Items 23 to 51 'implementation of a management plan' includes counselling services.

A.5.6 Items 1 to 51 include advice to patients and/or relatives during the course of an attendance. The advising of relatives at a later time does not extend the time of attendance.

Recording Clinical Notes

A.5.7 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance A.5.8

Where, during the course of a single attendance by a general practitioner, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes for further details).

After Hours Services

A.5.9 There are no differential Schedule fees for medical services rendered after hours, except in relation to the items for emergencies ie items [1](#), [2](#), [601](#), [602](#). However, use of these emergency after hours items are restricted to situations as outlined in paragraph A.10 below.

Locum-Tenens

A.5.10 Where a general practitioner engages, either as an assistant or as a locum tenens, a medical practitioner who is not a general practitioner, Medicare benefits in respect of attendances rendered by the latter are attracted under Items [52-96](#) and not under Items [1-51](#).

A.6 Professional Attendances at an Institution (Items [13](#), [25](#), [38](#), [48](#), [81](#), [83](#), [84](#), [86](#))

A.6.1 For the purposes of these items an "institution" means a place (not being a hospital or residential aged care facility) at which residential accommodation or day care or both such accommodation and such care is made available to:-

- (a) disadvantaged children;
- (b) juvenile offenders;
- (c) aged persons;
- (d) chronically ill psychiatric patients;
- (e) homeless persons;
- (f) unemployed persons;

- (g) persons suffering from alcoholism;
- (h) persons addicted to drugs; or
- (i) physically or intellectually disabled persons.

Note: See also paragraph A.9

A.7 Attendances at a Hospital (Items [19](#), [33](#), [40](#), [50](#), [87](#), [89](#), [90](#), [91](#))

A.7.1 These items refer to attendances on patients admitted to a hospital or day hospital facility. Where medical practitioners have made arrangements with a local hospital to routinely use out-patient facilities to see their private patients, surgery consultation items would apply.

Note: See also paragraph A.9

A.8 Residential Aged Care Facility Attendances (Items [20](#), [35](#), [43](#), [51](#), [92](#), [93](#), [95](#), [96](#))

A.8.1 These items refer to attendances on patients in residential aged care facilities.

A.8.2 Where a medical practitioner attends a patient in a self-contained unit, within a residential aged care facility complex, the attendance attracts benefits under the appropriate home visit item.

A.8.3 Where a patient living in a self-contained unit attends a medical practitioner at consulting rooms situated within the precincts of the residential aged care facility, or at free standing consulting rooms within the residential aged care facility complex, the appropriate surgery consultation item applies.

A.8.4 If a patient who is accommodated in the residential aged care facility visits a medical practitioner at consulting rooms situated within the residential aged care facility complex, whether free standing or situated within the residential aged care facility precincts, benefits would be attracted under the appropriate residential aged care facility attendance item. Note: See also paragraph A.9

A.9 Attendances at Hospitals, Residential Aged Care Facility and Institutions and Home Visits

A.9.1 To facilitate assessment of the correct Medicare rebate in respect of a number of patients attended on the one occasion at one of the above locations, it is important that the total number of patients seen be recorded on each individual account, receipt or assignment form. For example, where ten patients were visited (for a brief consultation) in the one residential aged care facility on the one occasion, each account, receipt or assignment form would show "Item 20 - 1 of 10 patients" for a General Practitioner.

A.9.2 The number of patients seen should not include attendances which do not attract a Medicare rebate (eg. public in-patients, attendances for normal after-care), or where a Medicare rebate is payable under an item other than these derived fee items (eg. health assessments, care planning, emergency after-hours attendance - first patient).

A.10 Emergency After-Hours Attendances (Items [1](#), [2](#), [97](#), [98](#), [448](#), [449](#), [601](#), [602](#), [697](#), [698](#))

A.10.1 Items [1](#), [2](#), [97](#), [98](#), [448](#), [449](#), [601](#), [602](#), [697](#), [698](#) should only be itemised in the following instances -
the consultation is initiated by or on behalf of the patient in the same unbroken after-hours period (see para A.10.3);
the patient's medical condition must require immediate treatment; and
if more than one patient is seen on the one occasion, Items [1](#), [2](#), [97](#), [98](#), [448](#), [449](#), [601](#), [602](#), [697](#), [698](#) can be used but only in respect of the first patient. The normal items for the particular location should be itemised in respect of the second and subsequent patients attended on the same occasion.

Where the patient is seen at a public hospital the following additional provisions would apply in relation to Items [1](#), [97](#), [601](#) and [697](#) -

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

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

A.10.2 Items [2](#), [98](#), [448](#), [449](#), [602](#) and [698](#) are intended to allow benefit for returning to and specially opening up consulting rooms to attend a patient who needs immediate treatment after hours. As the extra benefit is for the inconvenience of actually returning to and opening the surgery it is payable only once on any one occasion - to the first patient seen after opening up. If other patients are seen on the same occasion they are itemised as ordinary surgery attendances. In this respect Items [2](#), [98](#), [602](#) and [698](#) are the same as Items [1](#), [97](#), [601](#) and [697](#).

Definition of After Hours

A.10.3 An after hours consultation or visit is a reference to an attendance on a public holiday, on a Sunday, before 8 am or after 1 pm on a Saturday, or at any time other than between 8 am and 8 pm on a week day not being a public holiday.

A.10.4 Where a practice or clinic routinely conducts its business during hours other than those quoted above, it would be necessary for the emergency service to be initiated and rendered outside the hours normally observed by that practice or clinic for it to attract a Medicare rebate under Items [1](#), [2](#), [97](#), [98](#), [448](#), [449](#), [601](#), [602](#), [697](#) or [698](#).

A.10.5 Items [449](#), [601](#), [602](#), [697](#) and [698](#) are intended to allow benefit for emergency attendances in the 'unsociable hours', that is, 11pm-7am on any day of the week. Apart from the time restriction, the conditions applying to Items [601](#) and [697](#) are the same as those applying to Items [1](#) and [97](#), and the conditions applying to Items [449](#), [602](#) and [698](#) are the same as those applying to Items [2](#), [98](#) and [448](#).

A.11 Minor Attendance by a Consultant Physician (Items 119, 131)

A.11.1 The Health Insurance Regulations provide that a minor consultation is regarded as being a consultation in which the assessment of the patient does not require the physical examination of the patient and does not involve a substantial alteration to the patient's treatment. Examples of consultations which could be regarded as being 'minor consultations' are listed below (this is by no means an exhaustive list) :-

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

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

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

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

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

A.13.1 These items refer to family group therapy supervised by medical practitioners other than consultant psychiatrists. To be used, these items require that a formal intervention with a specific therapeutic outcome, such as improved family function and/or communication, is undertaken. Other types of group attendances do not attract benefits. It should be noted that only one fee applies in respect of each group of patients.

A.14 Acupuncture (Item 173, 193, 195)

A.14.1 The service of "acupuncture" must be performed by a medical practitioner and itemised under Item 173, 193 or 195 to attract benefits. These items cover not only the performance of the acupuncture but include any consultation on the same occasion and any other attendance on the same day for the condition for which acupuncture was given. Items 193 and 195 may only be performed by a general practitioner, (see Note 4 of 'Medicare Benefit Arrangements' for a definition).

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

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

A.15 Psychiatric Attendances (Item 319)

A.15.1 Medicare benefits are attracted under Item 319 only where patients are diagnosed as suffering from:
severe personality disorder (predominantly from cluster B groupings), or in persons under 18 years of age a severe disruption of personality development; or
anorexia nervosa; or
bulimia nervosa; or
dysthymic disorder; or
substance-related disorder; or
somatoform disorder; or
a pervasive developmental disorder (including autism and Asperger's disorder)

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

A.15.2 It is not sufficient for the patient's illness to fall within the diagnostic criteria. It must be evident that a significant level of impairment exists which interferes with the patient's quality of life. For persons 18 years and over, the level of impairment must be within the range 1 to 50 of the Global Assessment of Functioning (GAF) Scale contained in the DSM-IV (ie. the patient is displaying at least "serious" symptoms). The GAF score, incorporating the parameters which have led to the score, should be recorded at the time of commencement of the current course of treatment. Once a patient is identified as meeting the criteria of item 319, he/she continues to be eligible under that item for the duration of the current course of treatment (provided that attendances under items 300 to 308 and 319 do not exceed 160 in a calendar year). Where a patient commences a new course of treatment, the GAF score in relation to item 319 is the patient's score as assessed during the new course of treatment.

A.15.3

In addition to the above diagnostic criteria and level of functional impairment, it is also expected that other appropriate psychiatric treatment has been used for a suitable period and the patient has shown little or no response to such treatment. It is expected that such treatment would include, but not be limited to: shorter term psychotherapy; less frequent but long term psychotherapy; pharmacological therapy; cognitive behaviour therapy.

A.15.4 It is the responsibility of the psychiatrist to ensure that the patient meets these criteria. The Health Insurance Commission will be closely monitoring the use of Item 319.

A.15.5 When a patient who meets the criteria defined in Item [319](#) attends a psychiatrist on more than 160 occasions in 12 months such attendances would be covered by Items [310](#) to [318](#).

A.15.6 The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has undertaken to establish an appropriate mechanism to enable use of Item [319](#) by suitably trained psychiatrists. In the interim it is expected that psychiatrists whose usual practice includes long term intensive treatment of patients whose diagnoses meet the criteria defined in the item will be using Item 319.

A.15.7 On the basis of advice from the RANZCP it is expected that it would be generally inappropriate in normal clinical practice for psychiatric treatment performed out of hospital to extend beyond 220 sessions in any 12 month period. In this regard the Health Insurance Commission will be monitoring providers' practice patterns with a view to the referral of possible cases of inappropriate practice to the Director of Professional Services Review.

A.16 Interview of Person other than a Patient by Consultant Psychiatrist (Items [348](#), [350](#), [352](#))

A.16.1 Items [348](#) and [350](#) refer to investigative interviews of a patient's relatives or close associates to determine whether the particular problem with which the patient presented was focused in the patient or in the interaction between the patient and the person being interviewed. These items do not cover counselling of family or friends of the patient. The term "in the course of initial diagnostic evaluation of the patient" should normally be interpreted as extending for up to one month from the date of the initial consultation. There is no strict limit to the number of interviews or persons interviewed in that period. These items should not be used for interviews concerned with the continuing management of the patient. (See para A.16.2)

A.16.2 Item [352](#) refers to investigative interviews of a patient's relatives or close associates to focus on a particular clinically relevant problem arising in the continuing management of the patient. This item does not cover counselling of family or friends of the patient. The payment of Medicare benefits under this item is limited to four in any twelve month period.

A.16.3 Benefits are payable for Item [348](#), [350](#) or [352](#) and for a consultation with a patient (Items [300](#) - [328](#)) on the same day provided that separate attendances are involved.

A.16.4 For Medicare benefit purposes, charges relating to services covered by Items [348](#), [350](#) and [352](#) should be raised against the patient rather than against the person interviewed.

A.17 Consultant Occupational Physician attendances (Items [385](#) to [388](#))

A.17.1 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 non-compensable 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.

A.18 Contact Lenses (Items [10801](#)-[10809](#))

A.18.1 Benefits are paid for consultations concerned with the prescription and fitting of contact lenses only if patients fall into specified categories (ie. patients with certain conditions). The classes of patients eligible for benefits for contact lens consultations are described in Items [10801](#) to [10809](#). Benefits are not payable for Item [10809](#) in circumstances where patients want contact lenses only for:

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

A.18.2 Benefits are payable for an initial referred consultation rendered in association with the fitting and prescribing of the lenses.

A.18.3 Subsequent follow-up attendances attract benefits on a consultation basis.

A.19 Refitting of Contact Lenses (Item [10816](#))

A.19.1 This item covers the refitting of contact lenses where this becomes necessary within the thirty-six month time limit where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structure or functional change in the eye or an allergic response.

A.20 Health Assessments (Items [700](#) to [706](#))

A.20.1 These items do not apply to in-patients of a hospital, day hospital facility or care recipients in residential aged care facilities.

A.20.2 A health assessment should generally only be undertaken by the medical practitioner, or a practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.20.3 The information collection component of the assessment may be rendered by a nurse or other assistant in accordance with accepted medical practice, acting under the supervision of the medical practitioner. The other components of the health assessment must include a personal attendance by the medical practitioner.

A.20.4 For the purposes of A20.3, the services of a third party service provider such as a nurse or other assistant may only be used to assist in the information collection component of health assessments where:

- (a) use of the third party service provider is initiated by the patient's medical practitioner, after the patient has agreed to a health assessment and to the use of a third party to collect information for the assessment; and
- (b) the patient is made aware whether information collected about them for the health assessment will be retained by the third party service provider; and
- (c) the third party service provider must act under the supervision of the practitioner. The practitioner should:
 - be satisfied that the third party service provider has the necessary skills, expertise and training to collect the information required for the health assessment;
 - have established how the information is to be collected and recorded (including any forms used);
 - set or approve the quality assurance procedures for the information collection;
 - be consulted on any issues arising during the information collection; and
 - review and analyse the information collected to prepare their report of the health assessment and communicate to the patient their recommendations about matters covered by the health assessment.

A.20.5 For items 704 and 706, a person is of Aboriginal or Torres Strait Islander descent if the person identifies himself or herself as being of that descent. Patients should be asked to self-identify their Indigenous status and state their age for the purposes of these items, either verbally or by completing a form. Difficulties may arise in relation to establishing the age of the patient. Knowledge of a person's age or date of birth is sometimes considered irrelevant by Indigenous people and as such some people may not be able to answer with a high degree of accuracy. The person's Indigenous status and age should be accepted on the basis of their self-identification.

A.20.6 A health assessment means the assessment of a patient's health and physical, psychological and social function and whether preventative health care and education should be offered to the patient, to improve that patient's health and physical, psychological and social function.

A.20.7 The assessment must include:

- (a) measurement of the patient's blood pressure, pulse rate and rhythm; and
- (b) an assessment of the patient's medication; and
- (c) an assessment of the patient's continence; and
- (d) an assessment of the patient's immunisation status for influenza, tetanus and pneumococcus; and
- (e) an assessment of the patient's physical function, including the patient's activities of daily living, and whether or not the patient has had a fall in the last 3 months; and
- (f) an assessment of the patient's psychological function, including the patient's cognition and mood; and
- (g) an assessment of the patient's social function, including the availability and adequacy of paid and unpaid help, and whether the patient is responsible for caring for another person.

A.20.8 The assessment must also include keeping a record of the health assessment and offering the patient a written report about the health assessment, with recommendations about matters covered by the health assessment. Where the patient has an informal or family carer, a copy of the report (or relevant extracts) should be offered to the carer, with the patient's agreement.

Note: An informal or family carer is usually a family member who provides support to children or adults who have a disability, mental illness, chronic condition or who are frail aged. Carers can be parents, partners, brothers, sisters, friends or children of any age. Carers may care for a few hours a week, or all day every day. Some carers are eligible for government benefits, while others are employed or have a private income.

A.20.9 In circumstances where the patient's usual medical practitioner or practice, as defined in A20.2, does not undertake the health assessment, a copy of the health assessment report should be forwarded to that medical practitioner or practice (subject to the patient's agreement).

A.20.10 The annual health assessment should not take the form of a health screening service, in particular the assessment should not include category 5 (diagnostic imaging) services or category 6 (pathology) services unless the health assessment detects problems that require clinically relevant diagnostic imaging or pathology services. (See General Notes [13.3](#).)

A.20.11 Practitioners should not conduct a separate consultation in conjunction with a health assessment unless it is clinically indicated that a problem must be treated immediately.

A.20.12 Practitioners should establish a register of their patients seeking annual health assessments and remind registered patients when their next health assessment is due.

A.20.13 Where a component of the health assessment is conducted at consulting rooms and a component is conducted in the patient's home (including by a third party acting under the supervision of the practitioner) the latter item should be claimed.

A.20.14

The balance between the patient's health and physical, psychological and social function domains is a matter for professional judgement in relation to each patient. Practitioners should consider the following:

Medical: Medication review

This should include a review of medications taken including OTCs and prescriptions from other doctors; medications prescribed but not taken; interactions; and review of indications. In this age group, the side effects and interactions of medications occur more frequently and at lower dosage than in younger adults.

Blood pressure and pulse rate and rhythm

Where the assessment identifies a spot high blood pressure reading or evidence of atrial fibrillation (irregularly irregular pulse), a follow up consultation should be arranged to determine further management.

Continence

Continence problems are under reported and a major cause of reduced quality of life in this age group. They are usually easily detectable by direct questioning, and when first diagnosed are frequently amenable to improved management. If identified, a follow up consultation should be arranged to investigate the underlying pathology and arrange management.

Immunisation status (Influenza, Tetanus, Pneumococcus)

Refer to the current Australian Standard Vaccination Schedule (NHMRC) for appropriate vaccination schedules for individuals in this age group.

Physical function:

Activities of Daily Living

Assessment of activities of daily living is concerned with the interaction between the patient, their impairment (if any) and their environment. As a minimum, the patient's ability to transfer between bed, chair and toilet, bathe, dress, prepare food and eat should be assessed. The assessment should also include whether the patient can: use the telephone; get to the shops or the bank; read books; watch TV; listen to the radio or recorded music; and look after the house (cleaning, minor repairs etc).

Where significant functional impairment is identified, the use of a formal instrument such as the Index of Independence in Activities of Daily Living; the Modified Barthel Index; or the Medical Outcome Study Physical Functioning Measure should be considered.

Falls in last 3 months

The patient should be asked whether they have suffered any falls in the previous three months. A recent fall is the strongest predictor of future fall related injury.

Psychological function:

Cognition

Unrecognised dementia is common in this age group. Detailed diagnosis can often improve quality of life. Where problems with cognition are suspected clinically, assessment with a recognised tool such as the Folstein Mini Mental State Examination or the Hodkinson Abbreviated Mental Assessment may be appropriate.

Mood

At a minimum, the assessment should include enquires about depressed affect. If mental symptoms are present (eg abnormal affect or memory loss), the use of a formal depression scale such as the Geriatric Depression Scale may be considered.

Social function:

Availability and adequacy of paid and unpaid help when needed and wanted

This is the central component of an assessment of the patient's social support. People's social networks tend to become smaller as they age, and the role of formal services may need to increase correspondingly.

Caring for another person

Being a carer for another person can significantly affect physical and psychological health and substantially reduce opportunities to maintain social networks. When the person being assessed is a carer, the assessment should include: an evaluation of the effect of this role on health and functioning; and the provision of information about local carer support services, including regular or emergency respite care.

Consultation with patient's carer

Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the health assessment or components thereof (subject to the patient's agreement). The patient's carer may be able to provide useful information on matters such as medication usage and compliance, continence, and physical, psychological and social function. The practitioner may also consider the degree of the patient's reliance on the carer, the capacity of the carer to provide support to the patient, and strategies to improve the patient's independence.

NB: The tools referred to in the preceding explanatory notes should be used at the clinical discretion of the practitioner. Practitioners using such tools should be familiar with their use and if not, should seek appropriate education/training.

A.20.15 In addition, the assessment will usually cover additional matters of particular relevance to the patient. The medical literature and consensus medical opinion support the following additional components: multi-system review; fitness to drive; hearing; vision; oral health; diet and nutritional status; smoking; foot care; sleep; need for community services; home safety; cardiovascular risk factors, including blood pressure; and alcohol use.

A.21 EPC Multidisciplinary Care Planning (Items 720 to 730)

A.21.1 EPC multidisciplinary team care planning is a specific, defined approach to care planning. An EPC multidisciplinary team care plan is a written, comprehensive, longitudinal plan for the care of patients with one or more chronic conditions and complex care needs, developed and managed by a multidisciplinary team comprising the patient's GP and other health and care providers. EPC multidisciplinary care planning involves team-based management of the patient's complex care needs.

A.21.2 The development or review of an EPC multidisciplinary team care plan involves collaboration by the members of the team. Each of the members of the team must contribute to the development or review of the plan and not simply provide a service specified in the plan to the patient.

Chronic conditions and complex care needs A.21.3

To be eligible for a Medicare rebate EPC multidisciplinary team care plans and case conferences may only be provided for patients with one or more chronic conditions and complex care needs requiring multidisciplinary care from a team of health and care providers, including the patient's GP.

A.21.4 A chronic medical condition is a medical condition that has been, or is likely to be, present for at least 6 months, or that is terminal. EPC multidisciplinary team care plans and case conferences have been found to be most useful for patients with complex care needs, *for example*, where routine management of the condition is compounded by the presence of one or more of the following: unstable or deteriorating condition; increasing frailty and/or dependence; development of complications, including falls or incontinence; co-morbidities; significant change in social circumstances (eg death, illness or 'burnout' of carer); or two or more hospital admissions in the past six months.

Items 720 - 730: Application

A.21.5 Items 720, 724 and 726 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and IS NOT an in-patient of a hospital, day hospital facility, or a care recipient in a residential aged care facility.

A.21.6 Items 722 and 728 apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and IS an in-patient of a hospital or day hospital facility, and IS NOT a care recipient in a residential aged care facility.

A.21.7 Item 730 applies only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.21.8 For the purposes of items 720 to 730 a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

Preparation of an EPC multidisciplinary care plan

A.21.9 For items 720, 722, 724, 726, 728 and 730 preparation of an EPC multidisciplinary team care plan means the preparation of a written plan in collaboration with all of the members of a multidisciplinary care plan team, describing the following matters:

- (i) an assessment of the patient which considers their current and future health and care needs (refer to note A.21.4); and
- (ii) management goals with which the patient agrees; and
- (iii) an assessment of the kinds of treatment, health services and health care that the patient is likely to need; and
- (iv) an assessment of any other kind of services and care that the patient is likely to need (for example, home and community care services); and
- (v) arrangements for giving the treatment, services and care referred to in paragraph (b); and
- (vi) arrangements to review the plan by a day specified in the plan (if this review is to be claimed as an EPC care plan review item it must be done in collaboration with all of the other members of the EPC multidisciplinary care plan team; if the review is undertaken by the GP alone it should be claimed as a normal consultation item).

A.21.10 Preparation of the plan must also include:

- (a) a meeting with the patient (and the patient's carer, where appropriate in the practitioner's view and with the patient's agreement) to discuss the preparation of the plan; and
- (b) telling the patient who will be included in the multidisciplinary care plan team; and
- (c) collaborating with all of the other members of the multidisciplinary care plan team to identify the patient's needs, the management goals that should be documented in the plan, the ongoing care and services to be provided by each member of the team, and any other services that may be required from other health and care providers to achieve the management goals in the plan;
- (d) recording the plan and the patient's agreement to the preparation of the plan; and
- (e) giving copies of relevant parts of the plan to the other members of the multidisciplinary care plan team and to any

- (f) other persons who, under the plan, will give the patient the treatment, service and care mentioned in the plan; and offering a copy of the plan (and evidence of the contribution made to the plan by members of the team) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer).

A.21.11 A multidisciplinary care plan team includes a medical practitioner and at least two other members who collaborate with the medical practitioner in the development of the plan and contribute to the implementation of the plan. Each of the members of the multidisciplinary care plan team must provide a different kind of care or service to the patient. One of the members of the team may be another medical practitioner (normally a specialist or consultant physician).

Example

Examples of persons who, for the purposes of care planning and case conferencing may be included in an EPC multidisciplinary care plan team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers; where they are contributing to the plan and not simply providing a service identified in the plan.

The involvement of a patient's carer in an EPC multidisciplinary care plan team can provide significant benefits in terms of input to the development of the plan and coordination of care for the patient. Where the patient has a carer, the practitioner should consider inviting the carer to be an additional member of the EPC multidisciplinary care plan team, with the patient's agreement and having regard to:

- the patient's circumstances;
- the degree of support provided by the carer for the patient; and
- the capacity of the carer to provide ongoing support to the patient and contribute to the work of the team.

Where the patient's carer is not a member of the EPC multidisciplinary care plan team, the practitioner should involve the patient's carer and provide information to the carer where appropriate and with the patient's agreement.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

A.21.12 The development or review of an EPC multidisciplinary team care plan involves collaboration between the members of the team. Collaboration should be based on communication between the members of the team, preferably either in person, by telephone or by videoconferencing. Where it is not practicable to communicate by these means, communication in the development or review of an EPC care plan may be by two-way exchange of e-mails or faxes.

A.21.13 In making arrangements for implementation of the plan, the medical practitioner, in collaboration with the other members of the EPC multidisciplinary care plan team, should specify the type of care to be provided and ascertain the availability of care from other providers, taking into account any care and support provided by the patient's carer and the carer's capacity to provide ongoing support. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement. The documentation of the care plan should note the agreement of the other providers specified in the plan. This may be in the form of the medical practitioner's note of a face-to-face meeting, telephone conversation, videoconference, or two-way exchange of e-mails or faxes.

A.21.14 While the patient must be present for a needs assessment by the medical practitioner in order to develop the care plan, the patient need not be present while collaboration and consultation is undertaken with the other members of the EPC multidisciplinary care plan team and formal documentation is prepared.

A.21.15 When discussing the preparation of the plan with the patient, practitioners should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers; and
- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other members of the EPC multidisciplinary care plan team;
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable;
- Inform the patient of any additional costs he or she will incur.

A.21.16 While no standard format for the care plan is mandated, practitioners should consider a recognised care-planning tool, for example those developed by the Royal Australian College of General Practitioners (RACGP) or Divisions of General Practice.

A.21.17 It is recommended that a community care plan be prepared only once per year. However, a new plan may be prepared if in the judgement of the patient's usual medical practitioner there have been significant changes in the patient's clinical condition or in the patient's care support arrangements which have significantly affected their clinical condition since

the previous plan, but not within 6 months of the previous plan. Any changes to the plan required after 3 months of the plan being prepared would attract a benefit under the review item [724](#) (see paragraphs A.21.21 and A.21.22).

A.21.18 Ongoing implementation and maintenance of the plan by the medical practitioner will be covered under normal consultation items.

EPC Multidisciplinary Discharge care plans

A.21.19 For items [722](#) and [728](#) an EPC multidisciplinary discharge care plan is a multidisciplinary care plan that is prepared for a patient with a chronic condition and complex care needs before the patient is discharged from a hospital.

A.21.20 Preparation of a discharge care plan (item [722](#)) may be provided for private in-patients only, and must be prepared by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner). Medical practitioners may contribute to a discharge care plan (item [728](#)) for public in-patients.

Review of care plans

A.21.21 For item [724](#), review of an EPC multidisciplinary care plan means a process by which the medical practitioner who prepared the care plan, in collaboration with the other members of the EPC multidisciplinary care plan team:

- (a) reviews a community care plan or discharge care plan prepared under item [720](#) or [722](#) including reviewing the matters mentioned in A.21.9; and
- (b) considers whether the arrangements for treatment, service and care have been carried out; and
- (c) collaborates with each of the other members of the EPC multidisciplinary care plan team to consider whether different arrangements need to be made to achieve the management goals mentioned in the plan; and
- (d) if different arrangements need to be made, prepares a revised EPC multidisciplinary care plan, stating those arrangements.

A.21.22 The review of the plan must also include:

- (e) discussing the review of the plan with the patient (and the patient's carer, where appropriate); and
- (f) recording the patient's agreement to reviewing the plan; and
- (g) offering a copy of relevant parts of the revised EPC multidisciplinary care plan (if any) to the patient (and, if appropriate and with the patient's agreement, to the patient's carer), and giving copies to the other members of the EPC multidisciplinary care plan team and to any other persons who, under the revised plan, will give the patient the treatment, service and care mentioned in the plan.

Contribution to EPC multidisciplinary care plans

A.21.23 For items [726](#) and [728](#), a contribution to a care plan must be at the request of the person who prepares the plan, and may include preparation of a part of the plan that relates to the treatment, service or care that the medical practitioner will give to the patient and giving advice to the person who prepares the plan.

A.21.24 Contribution to a care plan does not include preparation of an EPC multidisciplinary *community* care plan, a multidisciplinary discharge care plan or a care plan in a residential aged care facility, but can include contribution to a review of a care plan organised by another provider.

A.21.25 A medical practitioner's contribution to a *community* care plan, a discharge plan or a care plan in a residential aged care facility should involve collaboration based on two-way communication between the GP and the person organising the care plan. This communication should preferably be either in person, by telephone or by videoconferencing. Where it is not practicable to communicate by these means, a GP's contribution to a care plan may be by two-way exchange of e-mails or faxes.

A.21.26 The medical practitioner should request a copy of the completed plan, or an extract of the plan relating to the medical practitioner's contribution, for the patient's medical record. The medical practitioner must include a record of his or her contribution in the patient's medical record.

A.21.27 For item [730](#), a contribution to an EPC multidisciplinary team care plan in a residential aged care facility must be at the request of the residential aged care facility. It is expected that a medical practitioner would not normally be required to contribute to an individual care plan in a residential aged care facility more than four times in a 12 month period. The medical practitioner's contribution should be documented in the care plan maintained by the residential aged care facility and a record of the contribution included in the care recipient's medical record.

General requirements

A.21.28 In circumstances where the patient's usual medical practitioner, as defined in A21.8, is not a member of the EPC multidisciplinary care plan team, a copy of the care plan should be forwarded to that medical practitioner (subject to patient's agreement).

A.21.29 Before commencing an EPC multidisciplinary team care plan, the medical practitioner should ascertain whether the patient currently has another active care plan and if so, should not duplicate that plan.

A.21.30 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided (see paragraph 7 of the General Explanatory Notes).

A.22 Case Conferences by medical practitioners (other than specialist or consultant physician) (Items 734 to 779)

A.22.1 Items [740](#), [742](#), [744](#), [759](#), [762](#) and [765](#) apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is not an in-patient of a hospital, day hospital facility or a care recipient in a residential aged care facility.

A.22.2 Items [746](#), [749](#), [757](#), [768](#), [771](#) and [773](#) apply only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and is an in-patient of a hospital or day hospital facility and is not a care recipient in a residential aged care facility.

A.22.3 Items [734](#), [736](#), [738](#), [775](#), [778](#) and [779](#) apply only to a service in relation to a care recipient in a residential aged care facility who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal.

A.22.4 A case conference is a process by which a case conference team carries out the following activities:

- (a) discussing a patient's history; and
- (b) identifying the patient's multidisciplinary care needs; and
- (c) identifying outcomes to be achieved by members of the case conference team giving care and service to the patient; and
- (d) identifying tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- (e) assessing whether previously identified outcomes (if any) have been achieved.

Where the patient has a carer, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient's carer without the carer's agreement.

A.22.5 For items [746](#), [749](#), [757](#), [768](#), [771](#) and [773](#), a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility.

A.22.6 For the purposes of items [734](#) to [779](#) a medical practitioner should generally be the medical practitioner or a practitioner working in the medical practice that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.22.7 A case conference team includes a medical practitioner and at least two other members, who participate in the case conference, each of whom provides a different kind of care or service to the patient, and one of whom may be another medical practitioner (normally a specialist or consultant physician).

The involvement of a patient's carer in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the practitioner should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient's agreement and where the carer's input is likely to be relevant to the subject matter of the case conference. The carer's membership of the team is in addition to the minimum three members.

Where the patient's carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient's agreement.

Example

Examples of persons who, for the purposes of care planning and case conferencing may be included in a multidisciplinary care team are allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

A team may also include home and community service providers, or care organisers, such as: education providers; "meals on wheels" providers; personal care workers (workers who are paid to provide care services); probation officers.

The patient's informal or family carer may be included as a formal member of the team in addition to the minimum of three health or care providers. The patient and the informal or family carer do not count towards the minimum of three.

Organisation of a case conference

A.22.8 Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

- (a) explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
- (b) recording the patient's agreement to the case conference; and
- (c) recording the day on which the conference was held, and the times at which the conference started and ended; and
- (d) recording the names of the participants; and
- (e) recording the matters mentioned in A.22.4 and putting a copy of that record in the patient's medical records; and
- (f) offering the patient (and the patient's carer, if appropriate and with the patient's agreement), and giving each other member of the team a summary of the conference; and
- (g) discussing the outcomes of the case conference with the patient.

A.22.9 Organisation of a discharge case conference (items [746](#), [749](#) and [757](#)), may be provided for private in-patients

only, and must be organised by the medical practitioner who is providing in-patient care (in most cases this should be the patient's usual medical practitioner).

Participation in a case conference

A.22.10 Participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes ensuring that the following activities are completed and documented in the patient's medical records:

- (a) explaining to the patient the nature of a case conference, and asking the patient whether he or she agrees to the medical practitioner participating in the case conference; and
- (b) recording the patient's agreement to the medical practitioner participating in the case conference; and
- (c) recording the day on which the conference was held, and the times at which the conference started and ended; and
- (d) recording the names of the participants; and
- (e) recording the matters mentioned in A.22.4 in so far as they relate to the medical practitioner's participation in the case conference, and putting a copy of that record in the patient's medical records; and
- (f) offering the patient (and the patient's carer, if appropriate and with the patient's agreement) a summary of the conference.

Case conferences in a residential aged care facility A.22.11

For items [734](#), [736](#), [738](#), [775](#), [778](#) and [779](#), organising or participating in a case conference in a residential aged care facility means undertaking the relevant activities referred to in A.22.4, A.22.8 and A.22.10. For these items the medical practitioner must give a record of the conference, or a record of the medical practitioner's participation in the conference, to the residential aged care facility, place a copy in the patient's medical records, and offer a copy to the patient and to the patient's carer, if appropriate and with the patient's agreement.

General requirements

A.22.12 In circumstances where the patient's usual medical practitioner, as defined in A.21.4, is not a member of the case conference team, a record of the case conference should be forwarded to that medical practitioner (subject to the patient's agreement).

A.22.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period.

A.22.14 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.22.15 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;
- provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and
- Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.
- Inform the patient of any additional costs he or she will incur.

A.22.16 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See General Notes [7.6](#))

A.23 Public Health Medicine (Items [410](#) to [417](#))

A.23.1 Attendances by public health physicians will attract Medicare benefits under the new items only where the attendance relates to one or more of the following:-

- i) management of a patient's vaccination requirements for accepted immunisation programs; or
- ii) prevention or management of sexually transmitted disease; or
- iii) prevention or management of disease due to environmental hazards or poisons; or
- iv) prevention or management of exotic diseases; or
- v) prevention or management of infection during outbreaks of infectious disease.

A.24 Case Conferences by consultant physician (Items [820](#) to [838](#))

A.24.1 Items [820](#), [822](#), [823](#), [825](#), [826](#) and [828](#) apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. Items [820](#), [822](#), [823](#), [825](#), [826](#) and [828](#) do not apply to an in-patient of a hospital or day hospital facility.

A.24.2 For items [830](#), [832](#), [834](#), [835](#), [837](#) and [838](#), a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items [830](#), [832](#), [834](#), [835](#), [837](#) and [838](#) are payable not more than once for each hospital admission.

- A.24.3 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.
- A.24.4 A case conference is a process by which a multidisciplinary team carries out the following activities:
- discusses a patient’s history;
 - identifies the patient’s multidisciplinary care needs;
 - identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
 - identifies tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
 - assesses whether previously identified outcomes (if any) have been achieved.
- A.24.5 For the purposes of items [820](#), [822](#), [823](#), [830](#), [832](#) and [834](#) (that is, where a consultant physician organises a case conference) a multidisciplinary team requires the involvement of a minimum of four formal care providers from different disciplines. The consultant physician is counted toward the minimum of four. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient’s usual General Practitioner) can be counted toward the minimum of four.
- A.24.6 For the purposes of items [825](#), [826](#), [828](#), [835](#), [837](#) and [838](#) (that is, where a consultant physician participates in a case conference) a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant physician is counted toward the minimum of three. Although they may attend the case conference, neither the patient nor his or her informal carer, or any other medical practitioner (except where the medical practitioner is the patient’s usual General Practitioner) can be counted toward the minimum of three.
- A.24.7 For the purposes of A.24.5 and A.24.6, “formal care providers” includes:
- the patient’s usual General Practitioner;
 - allied health professionals, being: registered nurse, physiotherapist, occupational therapist, podiatrist, speech pathologist, pharmacist; dietician; psychologist; orthoptist; orthotist and prosthetist, optometrist; audiologist, social worker, Aboriginal health worker, mental health worker, asthma educator, diabetes educator, dental therapist, dentist; and
 - community service providers being: personal care worker, home and community care service provider, meals on wheels provider, education provider and probation officer.

Organisation of a case conference

- A.24.8 For items [820](#), [822](#), [823](#), [830](#), [832](#) and [834](#), organise and coordinate a community case conference means undertaking the following activities in relation to a case conference:
- (a) explaining to the patient or the patient’s agent the nature of a case conference, and asking the patient or the patient’s agent whether he or she agrees to the case conference taking place; and
 - (b) recording the patient’s or agent’s agreement to the case conference; and
 - (c) recording the day on which the conference was held, and the times at which the conference started and ended; and
 - (d) recording the names of the participants; and
 - (e) recording the matters mentioned in A.24.4 and putting a copy of that record in the patient’s medical records; and
 - (f) giving the patient or the patient’s agent, and each other member of the team a summary of the conference; and
 - (g) giving a copy of the summary of the conference to the patient’s usual general practitioner; and
 - (h) discussing the outcomes of the patient or the patient’s agent.

Participation in a case conference

- A.24.9 For items [825](#), [826](#), [828](#), [835](#), [837](#) and [838](#), participation in a case conference must be at the request of the person who organises and coordinates the case conference and includes undertaking the following activities when participating in a case conference:
- (a) recording the day on which the conference was held, and the times at which the conference started and ended; and
 - (b) recording the matters mentioned in A.24.4 in so far as they relate to the medical practitioner’s participation in the case conference, and putting a copy of that record in the patient’s medical records.

General requirements

A.24.10 The case conference must be arranged in advance, within a time frame that allows for all the participants to attend. The minimum of three care providers for participating in a case conference or four care providers for organising a case conference must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.24.11 A record of the case conference which contains: a list of the participants; the times the conference commenced and concluded; a description of the problems, goals and strategies; and a summary of the outcomes must be kept in the patient’s record. The notes and summary of outcomes must be provided to all participants and to the patient’s usual general practitioner.

A.24.12 Prior informed consent must be obtained from the patient, or the patient’s agent. In obtaining informed consent the consultant physician should:

- Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other case conference participants;

- Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to, or withheld from, the other care providers;
- Inform the patient that he or she will incur a charge for the service for which a Medicare rebate will be payable.

A.24.13 Medicare benefits are only payable in respect of the service provided by the coordinating consultant physician or the participating consultant physician. Benefits are not payable for another medical practitioner organising a case conference or for participation by other medical practitioners at a case conference, except where a medical practitioner organises or participates in a case conference in accordance with Items [734](#) to [779](#).

A.24.14 The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. See point 7 of the General Explanatory Notes for further details on billing procedures.

A.24.15 It is expected that a patient would not normally require more than 5 case conferences in a 12 month period.

A.24.16 This item does not preclude the claiming of a consultation on the same day if other clinically relevant services are provided.

A.25 Attendances by Medical Practitioners who are Sports Physicians

A.25.1 Items [444](#) to [447](#) relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australian College of Sport Physicians (FACSP) and who participate in, and meet the requirements for, quality assurance and continuing medical education as required by the ACSP.

A.25.2 Items [444](#) to [447](#) cover four categories of attendance based largely on the tasks undertaken by the practitioner during the attendance on the patient rather than simply on the time spent with the patient.

A.25.3 The attendances are divided into four categories relating to the level of complexity, namely:

- (i) Level 1
- (ii) Level 2
- (iii) Level 3
- (iv) Level 4

A.25.4 To assist medical practitioners who are sports physicians in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL 1

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

LEVEL 2

The descriptions of these items introduce the words 'selective history' and 'implementation of a management plan in relation to one or more problems'. In this context a 'selective history' means a history relating to a specific problem or condition; and 'implementation of a management plan' includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels 1 and 2 relate not to time but to complexity.

LEVEL 3

Further levels of complexity are implied in these items by the introduction of 'taking a detailed history' and 'examination of multiple systems'. A physical attendance of at least 20 minutes is necessary to qualify for a Level 3 attendance. The words following 'OR' in the items for Levels 2 and 3 allow for the situation where an attendance involves some components of a more complex level but the time taken is less than specified in the higher level. Benefit is claimable at the appropriate lower level, eg - if an attendance involved a detailed history and examination of multiple systems, arranging investigations and implementing a management plan, but the time taken was less than 20 minutes, it would constitute a Level 2 attendance.

LEVEL 4

These items cover the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they should be performed. These items also cover cases which need prolonged discussion. Physical attendance of at least 40 minutes is necessary to qualify for a Level 4 attendance.

Recording Clinical Notes

A. 25.5 In relation to the time taken in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

Other Services at the Time of Attendance

A.25.6 Where, during the course of a single attendance by medical practitioners who are sports physicians, both a consultation and another medical service are rendered, Medicare benefits are generally payable for both the consultation and

the other service. Exceptions are in respect of medical services which form part of the normal consultative process, or services which include a component for the associated consultation (see paragraph 14.3 of the General Explanatory Notes for further details).

A.26 Domiciliary Medication Management Reviews

A.26.1 This item is available to people living in the community setting who meet the criteria for DMMR. The item is not available for in-patients of a hospital, day hospital facility, or care recipients in residential aged care facilities. Patients may also refer to DMMR as *Home Medicines Review*.

A.26.2 This item should generally be undertaken by the medical practitioner, or a medical practitioner working in the medical practice, that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.26.3 DMMR's are targeted at patients who are likely to benefit from such a review, and for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of their co-morbidities, age or social circumstances, the characteristics of their medicines, the complexity of their medication treatment regimen, or because of a lack of knowledge and skills to use medicines to their best effect.

A.26.4 A medical practitioner must assess that a DMMR is clinically necessary to ensure quality use of medicines or address patient's needs. Examples of risk factors known to predispose people to medication related adverse events are:

- currently taking 5 or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last 3 months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patients having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion/dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists; and
- recent discharge from a facility / hospital (in the last 4 weeks).

A.26.5 For item 900 a DMMR includes all DMMR-related services provided by the medical practitioner from the time the patient is identified as potentially needing a medication management review to the preparation of a draft medication management plan, and discussion and agreement with the patient.

- The potential need for a DMMR may be identified either by the medical practitioner in the process of a consultation or by receipt of advice from the patient, a carer or another health professional including a pharmacist.
- The medical practitioner must assess the clinical need for a DMMR from a quality use of medicines perspective with the patient as the focus, and formally initiate a DMMR if appropriate.
- If the DMMR is initiated during the course of a consultation undertaken for another purpose, this consultation may also be claimed separately.
- If the consultation at which the medication management review is initiated is only for the purposes of initiating the review only item 900 should be claimed.
- If the medical practitioner determines that a DMMR is not necessary, item 900 does not apply. In this case, normal consultation items should be used.
- The item covers the consultation at which the results of the medication management review are discussed and the medication management plan agreed with the patient. Any immediate action required to be done at the time of completing the DMMR (eg writing prescriptions or making referrals) should be treated as part of the DMMR item. Any subsequent follow up should be treated as a normal consultation item.
- Practitioners should not conduct a separate consultation in conjunction with completing the DMMR unless it is clinically indicated that a problem must be treated immediately.
- The benefit is not claimable and an account should not be rendered until all components of this item have been rendered (See General Notes 7, Billing Procedures).
- Where a DMMR cannot be completed due to circumstances beyond the control of the medical practitioner (for example, because the patient decides to not proceed further with the DMMR, or because of a change in the circumstances of the patient), the relevant MBS attendance items should be used.

A.26.6 The process of *referral to a community pharmacy* includes:

- Obtaining consent from the patient, consistent with normal clinical practice, for a pharmacist to undertake the medication management review and for a charge to be incurred for the service for which a Medicare rebate is payable. The patient must be clearly informed of the purpose and possible outcomes of the DMMR, the process involved (including that the pharmacist will visit the patient at home, unless the patient prefers another location or other exceptional circumstances apply), what information will be provided to the pharmacist as part of the DMMR, and any additional costs that may be incurred; and

- Provision to the patient's preferred community pharmacy, of relevant clinical information, by the medical practitioner for each individual patient, covering the patient's diagnosis, relevant test results and medication history, and current prescribed medications.
- A DMMR referral form is available for this purpose, if this form is not used the medical practitioner must provide patient details and relevant clinical information to the patient's preferred community pharmacy.

A.26.7 The **discussion of the review findings and report including suggested medication management strategies with the reviewing pharmacist** includes:

- Receiving a written report from the reviewing pharmacist; and
- Discussing the relevant findings and suggested management strategies with the pharmacist (either by phone or face to face); and
- Developing a summary of the relevant review findings as part of the draft medication management plan.

A.26.8 Development of **a written medication management plan following discussion with the patient** includes:

- Developing a draft medication management plan and discussing this with the patient; and
- Once agreed, offering a copy of the written medication management plan to the patient and providing a copy to the community pharmacist.

The agreed plan should identify the medication management goals and the proposed medication regimen for the patient.

A.26.9 Benefits for a DMMR service under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR (for example, diagnosis of a new condition or recent discharge from hospital involving significant changes in medication). In such cases the patient's invoice or Medicare voucher should be annotated to indicate that the DMMR service was required to be provided within 12 months of another DMMR service.

A.27 Taking a cervical smear from a woman who is unscreened or significantly under-screened (Items [2501 - 2509](#) and [2600 - 2616](#))

A.27.1 The item numbers [2501](#), [2503](#), [2504](#), [2506](#), [2507](#), [2509](#), [2600](#), [2603](#), [2606](#), [2610](#), [2613](#) and [2616](#) should be used in place of the usual attendance item where as part of a consultation, a medical practitioner takes a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years.

A.27.2 The items apply only to women between the ages of 20 and 69 inclusive who have a cervix, have had intercourse and have not had a cervical smear in the last four years.

A.27.3 When providing this service, the doctor must satisfy themselves that the woman has not had a cervical smear in the last four years by:

- asking the woman if she can remember having a cervical screen in the last four years; and -
- checking their own practice's medical records.

If significant uncertainty still remains, the doctor may also contact his/her state cervical screening register.

A.27.4 Women from the following groups are more likely than the general population to be unscreened or significantly under-screened - low socioeconomic status, culturally and linguistically diverse backgrounds, Indigenous communities, rural and remote areas and older women.

A.27.5 Vault smears are not eligible for items [2501 - 2509](#) and [2600 - 2616](#).

A.27.6 In addition to attracting a Medicare rebate, the use of these items will initiate a cervical screening incentive payment through the Practice Incentives Program (PIP).

A.27.7 From 1 November 2001, a PIP incentive for taking a cervical screen from women who have not been screened for four years became available. This incentive is paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. More detailed information on this incentive was provided separately to practices participating in the PIP and is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.28 Completion of an annual cycle of care for patients with diabetes mellitus (Items [2517 - 2526](#), [2620 - 2635](#))

A.28.1 The item numbers [2517](#), [2518](#), [2521](#), [2522](#), [2525](#), [2526](#), and [2620](#), [2622](#), [2624](#), [2631](#), [2633](#), [2635](#), should be used in place of the usual attendance item when a consultation completes the minimum annual requirements of care for a patient with established diabetes mellitus.

A.28.2 The minimum requirements of care are:

Assess diabetes control by measuring HbA _{1c}	At least once every year
Ensure that a comprehensive eye examination is carried out	At least once every two years
Measure weight and height and calculate BMI*	At least once every six months
Measure blood pressure	At least once every six months

Examine feet	At least once every six months
Measure total cholesterol, triglycerides and HDL cholesterol	At least once every year
Test for microalbuminuria	At least once every year
Provide self-care education Review diet	Patient education regarding diabetes management Reinforce information about appropriate dietary choices Reinforce information about appropriate levels of physical activity
Review levels of physical activity	Encourage cessation of smoking (if relevant)
Check smoking status	
Review of Medication	Medication review

Initial visit: measure height and weight and calculate BMI as part of the initial assessment. Subsequent visits: measure weight.

A.28.3 These requirements are based on the general practice guidelines produced by the Royal Australian College of General Practitioners and Diabetes Australia (DA/RACGP, *Diabetes Management in General Practice*, 6th ed., 2000). Doctors using these items should familiarise themselves with these guidelines and with subsequent editions of these guidelines as they become available.

A.28.4 Use of these items certifies that the minimum annual cycle of care has been completed for a patient with established diabetes mellitus in accordance with the guidelines above.

A.28.5 Use of these items is restricted to only one in a 12-month period, per patient of either [A18](#) Subgroup 2 or [A19](#) Subgroup 2. For example, if item [2517](#) is claimed for a patient then no other diabetes item in groups [A18](#) or [A19](#) can be used for this patient in the same 12-month period

A.28.6 The requirements for claiming this item are the minimum needed to provide good care to a patient with diabetes. Additional levels of care will be needed by insulin-dependent patients and those with abnormal review findings, complications and/or co-morbidities.

A.28.7 In addition to attracting a Medicare rebate, recording an annual completion of care cycle through the use of these items will initiate a diabetes incentive payment through the Practice Incentives Program (PIP).

A.28.8 From November 2001, PIP diabetes incentive payments became available for completion of an annual cycle of individual patient care. This incentive is only be paid once per year, per patient. The incentive is paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. A further payment through the PIP for practices reaching target levels of care for their patients with diabetes will be introduced in 2003. More detailed information on these incentives was provided separately to practices participating in the PIP and is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.29 Completion of the Asthma 3+ Visit Plan (Items [2546](#) - [2559](#), [2664](#) - [2677](#)) Minimum Requirements

A.29.1 The item numbers [2546](#), [2547](#), [2552](#), [2553](#), [2558](#), [2559](#) and [2664](#), [2666](#), [2668](#), [2673](#), [2675](#) and [2677](#) should be used in place of the usual attendance item when a consultation completes the requirements of the Asthma '3+Visit Plan'. The Asthma initiative is for patients with moderate to severe asthma who in the opinion of the doctor could benefit from review, eg those whose asthma management could be improved. At a minimum the Asthma 3+ Visit Plan must include:

- Documented diagnosis and assessment of severity,
- At least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma,
- Review of the patient's use of asthma related medication,
- Planned recalls for at least two of these consultations,
- Provision of a written asthma action plan and self-management education to the patient. (If the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record.) and
- Review of asthma action plan.

It is expected that at some point in the future, the use of spirometry will become a requirement of the diagnosis and assessment of severity for the purposes of the Asthma 3+ Visit Plan. All doctors will be given adequate notice of this change prior to its introduction.

The Asthma 3+Visit Plan should be provided to a patient by one GP or in exceptional circumstances by another GP within the same practice. In most cases, this will be the patient's usual medical practitioner. Completion of the Asthma 3+ Visit Plan does not preclude referral to a specialist, although a specialist consultation cannot be counted as one of the three visits.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient held written action plan.

These items will only be payable for the completion of one Asthma 3+ Visit Plan for each eligible patient per year, unless a further plan is clinically indicated by exceptional circumstances.

If a subsequent plan is indicated and the incentive item is to be claimed more than once per year for a patient, then the patient's invoice or Medicare voucher should be annotated to indicate that the Asthma 3+ Visit Plan was required to be provided within 12 months of another Asthma 3+ Visit Plan.

Assessment of Severity

A.29.2 Generally, patients who meet the following criteria can be assumed to have been assessed as having moderate to severe asthma:

Symptoms on most days, OR

Use of preventer medication, OR

Bronchodilator use at least 3 times per week, OR

Hospital attendance or admission following an acute exacerbation of asthma.

A.29.3 Where the general rule does not apply to a particular patient, the classification of severity described by the current edition of the National Asthma Council's *Asthma Management Handbook* can be used. The website address is:

www.NationalAsthma.org.au

A.29.4 Asthma 3+ Visit Plan

All visits should be billed under the normal attendance items with the exception of the visit that completes all of the minimum requirements of the Asthma 3+ Visit Plan as per A29.1

The minimum requirements of the Asthma 3+ Visit Plan may be carried out in 3, 4 or more visits as clinically required. The NAC recommendations below provide a guide for how the Asthma 3+ Visit Plan can be completed in 4 visits.

The visit that completes the Asthma 3+ Visit Plan should be billed using the appropriate item listed in Group [A18](#) and Group [A19](#) under Category 1- Professional Attendances. This will initiate the payment of an incentive through the Practice Incentives Program (PIP) in addition to attracting a Medicare rebate.

The National Asthma Council recommendations for their 3+ Visit Plan are as follows:

(NOTE: This is provided as a guide only and each case should be addressed on the patient's individual clinical needs)

Engagement Visit

If your patient presents solely for an asthma-related problem, or it is clinically appropriate and possible, include the items in Visit 1. However, there will often be visits at which your patient presents with an unrelated problem and doesn't mention asthma until the end of the consultation. In either case:

Manage the issue that caused asthma to be discussed, e.g. worsening asthma symptoms, request for a script (ensure that you record the asthma-related activities).

Introduce the concept of a 'partnership' for care: the **Asthma 3+ Visit Plan** and the reasons for review, and gain the patient's agreement.

Give the **Asthma 3+ Visit Plan handout** to the patient.

Visit 1

New patient: ascertain status, including history, medication and management. (Asthma Management Handbook p58-59)

Existing patient: assess present situation, including review of medical records and consolidation/collection of information on history, medication and management. (p58-59)

What do they know and what do they need to know? (knowledge) (p60-61 & p65-66)

Advise patient about their local Asthma Foundation's 3+ Community Support Program - telephone 1800 645 130

How do they feel about their asthma? (perception)

What do they want from you, the GP? (expectations)

Review medication devices technique and adherence. (p33, p55-57 & p62-63)

Perform physical examination (including spirometry). (p4-7 & p36)

Grade asthma severity and level of control. (p14-15 & p28)

Consider 2 weeks of peak expiratory flow rate (PEFR) recording and charting. (p6-7 & p36)

Is a change in medication required? (p22 & p32)

Agree on a date for the next visit.

Visit 2 (approximately 2 weeks later)

Review patient and his/her PEFR record.

Perform spirometry (if not already done, or consider redoing). (p4-5 & p36)

Complete written Asthma Action Plan or review existing plan. (p23-25 & p33-35)

Further identify trigger factors: consider RAST, skin-prick tests (if not already done). (p17-19 & p37)

Is a change in medication required? (p22 & p32)

Check on, reinforce and expand education. (p65-66)

Answer any questions.

Agree on a date for the next visit.

Visit 3 (approximately 4 weeks later) [This is where the relevant MBS asthma item should be claimed to trigger the PIP payment.]

Assess progress.

Review Asthma Action Plan.

Review medication requirements according to asthma control.

Discuss results of trigger factor tests (if applicable).

Check on, reinforce and expand education.

Answer any questions.

Subsequent visits (every 3 or 6 months as clinically appropriate) [These would be billed as usual consultation items.]

Assess progress and asthma control, including spirometry.

Review Asthma Action Plan and medication needs.

Emphasise the benefits of adherence and assess medication device technique.

Check on, reinforce and expand education.

Answer any questions.

All references are from Asthma Management Handbook 2002. National Asthma Council, Melbourne, 2002.

A.29.5 From 1 November 2001, PIP Asthma 3+ Visit Plan incentive payments became available for completing the minimum requirements of the Asthma 3+ Visit Plan as specified in clause A.29.1 above. This incentive is paid to the bank account nominated by the medical practitioner who provided the service, in accordance with individual practice arrangements, if the service was provided in a general practice participating in the PIP. More detailed information on this incentive was provided separately to practices participating in the PIP and is available from the HIC PIP enquiry line on 1800 222 032 or www.hic.gov.au/pip.

A.30 Completion of the 3 Step Mental Health Process (Items [2574](#), [2575](#), [2577](#), [2578](#) and [2704](#), [2705](#), [2707](#), [2708](#)) Minimum Requirements

A.30.1 From 1 July 2002, PIP Mental Health incentive payments will be available for providing the minimum requirements of the 3 Step Mental Health Process as specified in clause A.30.5 below. This incentive will be paid to the medical practitioner who provided the service if the service was provided in a general practice participating in the PIP or which is accredited.

A.30.2 The item numbers [2574](#), [2575](#), [2577](#), [2578](#) and [2704](#), [2705](#), [2707](#), [2708](#) can be accessed by practitioners who have completed the mental health Familiarisation Training and have the appropriate mental health skills as required by the General Practice Mental Health Standards Collaboration. Continued access to item numbers [2574](#), [2575](#), [2577](#), [2578](#) and [2704](#), [2705](#), [2707](#), [2708](#) will be dependent on the medical practitioner meeting ongoing education requirements as determined by the General Practice Mental Health Standards Collaboration.

A.30.3 The item numbers [2574](#), [2575](#), [2577](#), [2578](#) and [2704](#), [2705](#), [2707](#), [2708](#) should be used in place of the usual attendance item when a consultation completes the requirements of the 3 Step Mental Health Process.

A 30.4 Mental Health Disorder

A Mental Health disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder - this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care: ICD-10 Chapter V Primary Care Version. These disorders include:

Alcohol use disorders	Drug use disorders
Chronic psychotic disorders	Acute psychotic disorders
Bipolar disorder	Depression
Phobic disorders	Panic disorder
Generalised anxiety	Mixed anxiety and depression
Adjustment disorder	Dissociative (conversion) disorder
Unexplained somatic complaints	Neurasthenia
Eating disorders	Sleep problems
Sexual disorders	Hyperkinetic (attention deficit) disorder
Conduct disorder	Enuresis
Bereavement disorders	Mental disorder, not otherwise specified

but exclude dementia, delirium, tobacco use disorder and mental retardation.

A.30.5 3 Step Mental Health Process

At a minimum the 3 Step Mental Health Process must include:

- at least 3 consultations of more than 20 minutes each for a patient with an assessed mental health disorder;
- at least two of the consultations to have been planned visits;
- assessment and formulation or diagnosis of the mental health disorder/s;
- provision of a written mental health plan and appropriate education to the patient and/or carer (with patient's agreement); and
- review of the patient's progress against the goals included in the mental health plan. This review to have been conducted a minimum of 4 weeks and a maximum of 6 months from the consultation in which the mental health plan was prepared.

The patient's medical record should include documentation of each of these requirements and the clinical content of the patient-held mental health plan.

These items will only be payable for the completion of one 3 Step Mental Health Process for each eligible patient per year, unless a further plan is clinically indicated by exceptional circumstances.

If a subsequent 3 step process is indicated and the incentive item is to be claimed more than once per year for a patient, then the patient's invoice or Medicare voucher should be annotated to indicate that the 3 Step Mental Health Process was required to be provided within 12 months of another 3 Step Mental Health Process.

The 3 Step Mental Health Process must include three steps, 1) assessment, 2) preparation of a mental health plan and 3) review of the mental health plan. Multiple consultations may be required for any or all steps. At a minimum one consultation is required for each step.

All consultations conducted as part of the 3 Step Mental Health Process must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).

A.30.6 *Step 1 Assessment*

An assessment of a patient must include:

- taking a detailed biological, psychological and social history including the presenting complaint;
- conducting a mental state examination;
- conducting a risk assessment;
- a diagnosis and/or formulation; and
- the administration of an outcome tool, except where it is considered clinically inappropriate.

A formulation is important for the development of a mental health plan and includes an assessment of the biological, psychological and social factors predisposing, precipitating, perpetuating and/or protecting against a mental health problem.

In order to facilitate ongoing patient focussed management, an outcome tool will be utilised during the assessment and the review stages of the 3 Step Mental Health Process, except where it is considered clinically inappropriate. The choice of outcome tools to be used is at the clinical discretion of the practitioner, however the following outcome tools are recommended:

Recommended Outcome Tools

Kessler Psychological Distress Scale (K10)
Short Form Health Survey (SF12)
Health of the Nation Outcome Scales (HoNOS)

Practitioners using such tools should be familiar with their appropriate clinical use, and if not, should seek the appropriate education and training.

It should be noted that the outcome tools referred to above are not diagnostic tools.

Where the patient has a carer, the practitioner may find it useful to consider having the carer present for the assessment or components thereof (subject to patient agreement).

Consultations conducted as part of Step 1 (Assessment) should be billed under the normal attendance items.

A.30.7 *Step 2 Mental Health Plan*

Preparation of the mental health plan should be in consultation with the patient and/or carer (with agreement from the patient). A written copy of the mental health plan must be provided to the patient and/or carer (with agreement from the patient) where appropriate. Additionally a copy of the mental health plan must be kept in the patient's medical records.

If an assessment shows that it may be clinically appropriate to involve other health professionals in the patient's care it may be appropriate to prepare a multidisciplinary care plan. An Enhanced Primary Care (EPC) multidisciplinary care plan item (See Items [720](#) - [730](#)) may be claimed if the preparation of the mental health plan fulfils the conditions required for the EPC care plan. (See Note A21.5).

The development of a mental health plan must include: -

- discussion with the patient about the mental health formulation and/or diagnosis;
- discussion with the patient on treatment options including appropriate support services;
- provision of psycho-education;
- the written mental health plan must include a plan for treatment of the assessed mental health disorder/s and crisis intervention; and
- a plan for relapse prevention, if appropriate at this stage.

Treatment options could include psychological and pharmacological treatments, referral and coordination with community support and rehabilitation agencies, mental health services and other health professionals.

Consultations conducted as part of Step 2 (Mental Health Plan) should be billed under the normal attendance items.

A.30.8 *Step 3 Review of Mental Health Plan*

This step must occur a minimum of 4 weeks and a maximum of 6 months after the completion of step 2, the preparation of a mental health plan.

The review stage must include: -

- a review of the patient's progress against the goals outlined in the mental health plan;
- modification of the mental health plan if required;
- check, reinforce and expand education;
- a plan for relapse prevention if not previously provided; and
- re-administration of the outcome tool used in the assessment stage, except where considered clinically inappropriate.

Note: This review is a formal review point only and it is expected that there may be further consultations between the patient and the GP.

Step 3 should be billed under the appropriate item listed in Group [A18](#) or Group [A19](#) of the Medicare Benefits Schedule Book which list - Professional Attendances - which will initiate the payment of an incentive directly to the practitioner through the PIP, in addition to attracting a Medicare rebate.

A.31 Provision of Focussed Psychological Strategies (Items [2721](#) - [2727](#))

A31.1 Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies that have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. The decision to recommend Focused Psychological Strategies to a patient must be made in the context of a 3 Step Mental health Process.

Minimum Requirements

A31.2 All consultations providing Focussed Psychological Strategies must be rendered by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician). The service must be provided from a general practice that is either participating in the PIP or which is accredited.

A31.3 To ensure appropriate standards for the provision of Focussed Psychological Strategies, payment of Medicare rebates for these items will be limited to medical practitioners who are registered with the Health Insurance Commission to participate in the *Better Outcomes in Mental Health Care* initiative; and who satisfy the General Practice Mental Health Standards Collaboration that they have the required higher level mental health skills for provision of the service.

A31.4 Continued access to item numbers [2721](#) - [2727](#) will be dependent on the practitioner meeting the ongoing mental health education requirements as determined by the General Practice Mental Health Standards Collaboration.

A31.5 Patients will in general be permitted to claim Medicare rebates for up to 6 services under these item numbers per year, however in certain circumstances relating to the patient's clinical status, a further 6 services can be claimed per 12 month period. After one group of six services, the practitioner managing the 3 Step Mental Health Process must conduct a review, and the conclusion of the review noted on the patient's record, before a further 6 services may be provided.

Out-of-Surgery Consultation

A31.6 It is expected that this service would be provided only for patients who are unable to attend the practice.

Specific Focussed Psychological Strategies

A31.7 A range of acceptable strategies has been approved for use by medical practitioners in this context. These are:

1. Psycho-education

(including motivational interviewing)

2. Cognitive-behavioural Therapy including:

Behavioural interventions

Behaviour modification

Exposure techniques

Activity scheduling

Cognitive interventions

Cognitive therapy

3 Relaxation strategies

Progressive muscle relaxation
Controlled breathing

4 Skills training

Problem solving skills and training
Anger management
Social skills training
Communication training
Stress management
Parent management training

5. Interpersonal Therapy

Mental Health Disorder

A31.8 A mental health disorder may be defined as a significant impairment of an individual's cognitive, affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder - this definition is informed by the World Health Organisation, 1996, Diagnostic and Management Guidelines for Mental Disorders in Primary Care:ICD - 10 Chapter V Primary Health Care Version.

These disorders include:

Alcohol use disorders	Drug use disorders
Chronic psychotic disorders	Acute psychotic disorders
Bipolar disorder	Depression
Phobic disorders	Panic disorder
Generalised anxiety	Mixed anxiety and depression
Adjustment disorder	Dissociative (conversion) disorder
Unexplained somatic complaints	Neurasthenia
Eating disorders	Sleep problems
Sexual disorders	Hyperkinetic (attention deficit) disorder
Conduct disorder	Enuresis
Bereavement disorders	Mental disorder, not otherwise specified

But exclude dementia, delirium, tobacco use disorder and mental retardation.

A.33 Attendances by Medical Practitioners who are Emergency Physicians (Items 501 to 536)

A33.1 Items 501 to 536 relate specifically to attendances rendered by medical practitioners who are holders of the Fellowship of the Australasian College for Emergency Medicine (FACEM) and who participate in, and meet the requirements for, quality assurance and maintenance of professional standards by the ACEM.

A.33.2 Items 501 to 511 cover five categories of attendance based largely on the tasks undertaken in a recognised emergency medicine department of a private hospital by the practitioner during the attendance on the patient rather than simply on the time spent with the patient. The emergency department must be part of a hospital and this department must be licensed as an "emergency department" by the appropriate State government authority.

A.33.3 The attendances for items 501 to 515 are divided into five categories relating to the level of complexity, namely:

- (i) Level 1
- (ii) Level 2
- (iii) Level 3
- (iv) Level 4
- (v) Level 5

A33.4 To assist medical practitioners who are emergency physicians in selecting the appropriate item number for Medicare benefit purposes the following notes in respect of the various levels are given.

LEVEL 1

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

LEVEL 2

The description of this item introduces the words “expanded problem focussed history” and “formulation and documentation of a diagnosis and management plan in relation to one or more problems”. In this context an “expanded problem focussed history” means a history relating to a specific problem or condition; and “formulation and documentation of a management plan” includes formulation of the decision or plan of management and any immediate action necessary such as advising or counselling the patient, ordering tests, or referring the patient to a specialist medical practitioner or other allied health professional. The essential difference between Levels 1 and 2 relate not to time but to complexity.

LEVEL 3

Further levels of complexity are implied in these terms by the introduction of “medical decision making of moderate complexity”.

LEVEL 4

This item covers more difficult problems requiring the taking of a “detailed history” and “detailed examination of one or more systems”, with or without liaison with other health care professionals and subsequent discussion with the patient, his or her agent and/or relatives.

LEVEL 5

This item covers the difficult problems where the diagnosis is elusive and highly complex, requiring consideration of several possible differential diagnoses, and the making of decisions about the most appropriate investigations and the order in which they are performed. These items also cover cases which need prolonged discussion. It involves the taking of a comprehensive history, comprehensive examination and involving medical decision making of high complexity.

A33.5 In relation to the time in recording appropriate details of the service, only clinical details recorded at the time of the attendance count towards the time of consultation. It does not include information added at a later time, such as reports of investigations.

A34 Prolonged Attendance by an Emergency Physician in Treatment of a Critical Condition (Items 519 to 536)

A34.1 The conditions to be met before services covered by items 519 to 536 attract benefits are:

- (i) the patient must be in imminent danger of death ;
- (ii) the times relate to the total time spent with a single patient, even if the time spent by the physician is not continuous.

A.35 Case Conferences by Consultant Psychiatrists (855 to 866)

A.35.1 A range of new items has been introduced for case conferences by consultant psychiatrists in community settings and for discharge planning for hospital in-patients. These items are introduced to improve the effectiveness of psychiatric case conferences and facilitate for psychiatrists working with general practitioners and allied health professionals, thereby ensuring better coordinated care for patients. Three new items (855, 857 and 858) cover the organisation of a community case conference and a further three (861, 864 and 866) cover the organisation of a discharge case conference. Where a consultant psychiatrist organises a case conference a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines. The consultant psychiatrist and one other medical practitioner (other than a specialist or a consultant physician) are counted towards the minimum of three.

A.35.2 Items 855, 857, and 858 apply to a community case conference (including a case conference conducted in a residential aged care facility) organised to discuss one patient in detail and applies only to a service in relation to a patient who suffers from at least one medical condition that has been (or is likely to be) present for at least 6 months, or that is terminal. Items 855, 857, and 858 do not apply to an in-patient of a hospital or day hospital facility.

A.35.3 For items 861, 864 and 866 a discharge case conference is a case conference carried out in relation to a patient before the patient is discharged from a hospital or day hospital facility. Items 861, 864 or 866 are payable not more than once for each hospital admission.

A.35.4 The purpose of a case conference is to establish and coordinate the management of the care needs of the patient.

A.35.5 A case conference is a process by which a multidisciplinary team carries out the following activities:

- discusses a patient’s history;
- identifies the patient’s multidisciplinary care needs;
- identifies outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identifies tasks that need to be undertaken to achieve these outcomes, and allocates those tasks to members of the case conference team; and
- assesses whether previously identified outcomes (if any) have been achieved.

A.35.6 For the purposes of items 855 to 866, a multidisciplinary team requires the involvement of a minimum of three formal care providers from different disciplines, each of whom provides a different kind of care or service to the patient, and one of whom must be the patient's usual medical practitioner. The consultant psychiatrist and the medical practitioner are counted toward the minimum of three.

The patient's carer may be included as a member of the team (See A.35.8 below), in addition to the minimum of three health or care providers but do not count towards the minimum of three for Medicare purposes.

A.35.7 For the purposes of items [855](#) to [866](#) a consultant psychiatrist should generally be the consultant psychiatrist that has provided the majority of services to the patient over the previous 12 months and/or will provide the majority of services to the patient over the coming 12 months.

A.35.8 For the purposes of A.34.5, “formal care provider” includes in addition to the consultant psychiatrist and a medical practitioner (other than a specialist or consultant physician):

allied health professionals such as, but not limited to: Aboriginal health care workers; asthma educators; audiologists; dental therapists; dentists; diabetes educators; dieticians; mental health workers; occupational therapists; optometrists; orthoptists; orthotists or prosthetists; pharmacists; physiotherapists; podiatrists; psychologists; registered nurses; social workers; speech pathologists.

home and community service providers, or care organisers, such as: education providers; “meals on wheels” providers; personal care workers (workers who are paid to provide care services); probation officers.

A.35.9 The involvement of a patient’s carer, such as a friend or family member, in a multidisciplinary case conference team can provide significant benefits in terms of coordination of care for the patient. Where the patient has a carer, the consultant psychiatrist should consider inviting the carer to be an additional member of the multidisciplinary case conference team, with the patient’s agreement and where the carer’s input is likely to be relevant to the subject matter of the case conference. The involvement of the patient’s carer is not counted towards the minimum of three members.

A.35.10 Where the patient’s carer is not a member of the multidisciplinary team, the practitioner should involve the carer and provide information to the carer where appropriate and with the patient’s agreement. However, the practitioner should take account of the impact of the tasks identified in the case conference on the capacity of the carer to provide support to the patient. Additional responsibilities should not be assigned to the patient’s carer without the carer’s agreement.

Organisation of a case conference

A.35.11 Organise and coordinate a case conference means undertaking the following activities in relation to a case conference:

explaining to the patient the nature of a case conference, and asking the patient whether the patient agrees to the case conference taking place; and
recording the patient’s agreement to the case conference; and
recording the day on which the conference was held, and the times at which the conference started and ended; and
recording the names of the participants; and
recording the matters mentioned in A.34.4 and putting a copy of that record in the patient’s medical records; and
offering the patient (and the patient’s carer, if appropriate and with the patient’s agreement), and giving each other member of the team a summary of the conference; and
discussing the outcomes of the case conference with the patient.

General requirements

A.35.12 In circumstances where the patient’s usual medical practitioner, as defined in A.34.5, is not available to be a member of the case conference team, another medical practitioner known to the patient may be substituted.

A.35.13 It is expected that a patient would not normally require more than 5 case conferences in a 12-month period. A.35.14 The case conference must be arranged in advance within a time frame that allows for all the participants to attend. The minimum three care providers must be present for the whole of the case conference. All participants must be in communication with each other throughout the conference, either face to face, by telephone or by video link, or a combination of these.

A.35.15 In explaining to the patient the nature of a case conference and asking the patient whether he or she agrees to the case conference taking place, the medical practitioner should:

Inform the patient that his or her medical history, diagnosis and care preferences will be discussed with other care providers;

Provide an opportunity for the patient to specify what medical and personal information he or she wants to be conveyed to or withheld from the other case conference team members; and

Inform the patient that he or she will incur a charge for the service provided by the practitioner for which a Medicare rebate will be payable.

Inform the patient of any additional costs he or she will incur. The benefit is not claimable (and an account should not be rendered) until all components of these items have been provided. (See [General Notes 7.6](#))

FEES AND BENEFITS FOR GP ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY, HOSPITAL, INSTITUTION OR HOME

PATIENTS	FEE	LEVEL A		LEVEL B		
		BENEFITS		FEE	BENEFITS	
		85%	75%		85%	75%
ONE TWO	34.05	28.95	25.55	50.05	42.55	37.55
THREE	23.75	21.20	17.85	39.75	33.80	29.85
FOUR FIVE	20.30	17.30	15.25	36.30	30.90	27.25
SIX	18.60	15.85	13.95	34.60	29.45	25.95
SEVEN+	17.55	14.95	13.20	33.55	28.55	25.20
	16.90	14.40	12.70	32.90	28.00	24.70
	14.90	12.70	11.20	30.90	26.30	23.20

PATIENTS	FEE	LEVEL C		LEVEL D		
		BENEFITS		FEE	BENEFITS	
		85%	75%		85%	75%
ONE TWO	76.55	65.10	57.45	103.00	87.55	77.25
THREE	66.25	56.35	49.70	92.70	78.80	69.55
FOUR FIVE	62.80	53.40	47.10	89.25	75.90	66.95
SIX	61.10	51.95	45.85	87.55	74.45	65.70
SEVEN+	60.05	51.05	45.05	86.50	73.55	64.90
	59.40	50.50	44.55	85.85	73.00	64.40
	57.40	48.80	43.05	83.85	71.30	62.90

FEES AND BENEFITS FOR OTHER NON REFERRED ATTENDANCES (OTHER THAN CONSULTING ROOMS) AT A RESIDENTIAL AGED CARE FACILITY, HOSPITAL, INSTITUTION OR HOME

PATIENTS	FEE	BRIEF		STANDARD		
		BENEFITS		FEE	BENEFITS	
		85%	75%		85%	75%
ONE TWO	24.00	20.40	18.00	33.50	28.50	25.15
THREE	16.25	13.85	12.20	24.75	21.05	18.60
FOUR FIVE	13.70	11.65	10.30	21.85	18.60	16.40
SIX	12.40	10.55	9.30	20.40	17.35	15.30
SEVEN+	11.60	9.90	8.70	19.50	16.60	14.65
	11.10	9.45	8.35	18.95	16.15	14.25
	9.20	7.85	6.90	16.70	14.20	12.55

PATIENTS	LONG		PROLONGED			
	FEE	BENEFITS		FEE	BENEFITS	
		85%	75%		85%	75%
ONE TWO	51.00	43.35	38.25	73.00	62.05	54.75
THREE	43.25	36.80	32.45	65.25	55.50	48.95
FOUR FIVE	40.70	34.60	30.55	62.70	53.30	47.05
SIX	39.40	33.50	29.55	61.40	52.20	46.05
SEVEN+	38.60	32.85	28.95	60.60	51.55	45.45
	38.10	32.40	28.60	60.10	51.10	45.10
	36.20	30.80	27.15	58.20	49.50	43.65

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

EMERGENCY ATTENDANCES - AFTER HOURS

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

Professional attendance **AT A PLACE OTHER THAN CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance *other than an attendance between 11pm and 7am*, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.5 and A.10 of explanatory notes to this Category)*

1 **Fee:** \$93.70 **Benefit:** 75% = \$70.30 85% = \$79.65

Professional attendance **AT CONSULTING ROOMS** where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance *other than an attendance between 11pm and 7am*, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday *(See para A.5 and A.10 of explanatory notes to this Category)*

2 **Fee:** \$93.70 **Benefit:** 75% = \$70.30 85% = \$79.65

Professional attendance, at a place **OTHER THAN CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week *between 11pm and 7am* *(See para A.5 and A.10 of explanatory notes to this Category)*

601 **Fee:** \$112.05 **Benefit:** 75% = \$84.05 85% = \$95.25

Professional attendance, **AT CONSULTING ROOMS**, where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week *between 11pm and 7am* *(See para A.5 and A.10 of explanatory notes to this Category)*

602 **Fee:** \$112.05 **Benefit:** 75% = \$84.05 85% = \$95.25

GENERAL PRACTITIONER ATTENDANCES

LEVEL 'A'

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

SURGERY CONSULTATION
(Professional attendance at consulting rooms)
(See para A.5 of explanatory notes to this Category)

3 **Fee:** \$13.45 **Benefit:** 75% = \$10.10 85% = \$11.45

HOME VISIT
(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)
(See para A.5 of explanatory notes to this Category)

Derived Fee: The fee for item 3, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus \$1.45 per patient

4

CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY
(Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient
(See para A.5 and A.6 of explanatory notes to this Category)

Derived Fee: The fee for item 3, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus \$1.45 per patient

13

CONSULTATION AT A HOSPITAL
(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient
(See para A.5 and A.7 of explanatory notes to this Category)

Derived Fee: The fee for item 3, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus \$1.45 per patient

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ATTENDANCES	GENERAL PRACTITIONER
20	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 3, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 3 plus \$1.45 per patient</p>
23	<p style="text-align: center;">LEVEL 'B'</p> <p>Professional attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05</p>
24	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus \$1.45 per patient</p>
25	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus \$1.45 per patient</p>
33	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus \$1.45 per patient</p>
35	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 23, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 23 plus \$1.45 per patient</p>
36	<p style="text-align: center;">LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$55.95 Benefit: 75% = \$42.00 85% = \$47.60</p>
37	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 36, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus \$1.45 per patient</p>
38	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 36, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus \$1.45 per patient</p>

40	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient <i>(See para A.5 and A.7 of explanatory notes to this Category)</i> Derived Fee: The fee for item 36, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus \$1.45 per patient</p>
43	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 36, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 36 plus \$1.45 per patient</p>
44	<p style="text-align: center;">LEVEL 'D'</p> <p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.5 of explanatory notes to this Category)</i> Fee: \$82.40 Benefit: 75% = \$61.80 85% = \$70.05</p>
47	<p>HOME VISIT (Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution) <i>(See para A.5 of explanatory notes to this Category)</i> Derived Fee: The fee for item 44, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.45 per patient</p>
48	<p>CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient <i>(See para A.5 and A.6 of explanatory notes to this Category)</i> Derived Fee: The fee for item 44, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.45 per patient</p>
50	<p>CONSULTATION AT A HOSPITAL (Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient <i>(See para A.5 and A.7 of explanatory notes to this Category)</i> Derived Fee: The fee for item 44, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.45 per patient</p>
51	<p>CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY (Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) each patient <i>(See para A.5 and A.8 of explanatory notes to this Category)</i> Derived Fee: The fee for item 44, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 44 plus \$1.45 per patient</p>

ATTENDANCES		OTHER NON-REFERRED
	GROUP A2 - OTHER NON-REFERRED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES	
	SURGERY CONSULTATIONS	
	(Professional attendance at consulting rooms)	
52	BRIEF CONSULTATION of not more than 5 minutes duration Fee: \$11.00 Benefit: 75% = \$8.25 85% = \$9.35	
53	STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration Fee: \$21.00 Benefit: 75% = \$15.75 85% = \$17.85	
54	LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30	
57	PROLONGED CONSULTATION of more than 45 minutes duration Fee: \$61.00 Benefit: 75% = \$45.75 85% = \$51.85	
	HOME VISITS	
	(Professional attendance on 1 or more patients on 1 occasion at a place other than consulting rooms, hospital, residential aged care facility or institution)	
58	BRIEF HOME VISIT of not more than 5 minutes duration Derived Fee: An amount equal to \$8.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus \$.70 per patient	
59	STANDARD HOME VISIT of more than 5 minutes duration but not more than 25 minutes duration Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$.70 per patient	
60	LONG HOME VISIT of more than 25 minutes duration but not more than 45 minutes duration Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$.70 per patient	
65	PROLONGED HOME VISIT of more than 45 minutes duration Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$.70 per patient	
	CONSULTATION AT AN INSTITUTION OTHER THAN A HOSPITAL OR RESIDENTIAL AGED CARE FACILITY	
	(Professional attendance on 1 or more patients in 1 institution on 1 occasion) each patient	
81	BRIEF CONSULTATION of not more than 5 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$8.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus \$.70 per patient	
83	STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$.70 per patient	
84	LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$.70 per patient	
86	PROLONGED CONSULTATION of more than 45 minutes duration <i>(See para A.6 of explanatory notes to this Category)</i> Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$.70 per patient	

ATTENDANCES		OTHER NON-REFERRED
	CONSULTATION AT A HOSPITAL	
	(Professional attendance on 1 or more patients in 1 hospital on 1 occasion) each patient	
	BRIEF CONSULTATION of not more than 5 minutes duration <i>(See para A.7 of explanatory notes to this Category)</i>	
87	Derived Fee: An amount equal to \$8.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus \$.70 per patient	
	STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration <i>(See para A.7 of explanatory notes to this Category)</i>	
89	Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$.70 per patient	
	LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration <i>(See para A.7 of explanatory notes to this Category)</i>	
90	Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$.70 per patient	
	PROLONGED CONSULTATION of more than 45 minutes duration <i>(See para A.7 of explanatory notes to this Category)</i>	
91	Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$.70 per patient	
	CONSULTATION AT A RESIDENTIAL AGED CARE FACILITY	
	(Professional attendance on 1 or more patients in 1 residential aged care facility (but excluding a professional attendance at a self-contained unit) or attendance at consulting rooms situated within such a complex where the patient is accommodated in the residential aged care facility (excluding accommodation in a self-contained unit) on 1 occasion) - each patient	
	BRIEF CONSULTATION of not more than 5 minutes duration <i>(See para A.8 of explanatory notes to this Category)</i>	
92	Derived Fee: An amount equal to \$8.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$8.50 plus \$.70 per patient	
	STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration <i>(See para A.8 of explanatory notes to this Category)</i>	
93	Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$.70 per patient	
	LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration <i>(See para A.8 of explanatory notes to this Category)</i>	
95	Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$.70 per patient	
	PROLONGED CONSULTATION of more than 45 minutes duration <i>(See para A.8 of explanatory notes to this Category)</i>	
96	Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$.70 per patient	
	EMERGENCY ATTENDANCE - AFTER HOURS	
	(on not more than 1 patient on 1 occasion)	
	Professional attendance after hours AT A PLACE OTHER THAN CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment each attendance other than an attendance between 11pm and 7am , on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday	
+ 97	<i>(See para A.10 of explanatory notes to this Category)</i> Fee: \$80.30 Benefit: 75% = \$60.25 85% = \$68.30	
	Professional attendance AT CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance other than an attendance between 11pm and 7am , on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday	
+ 98	<i>(See para A.10 of explanatory notes to this Category)</i> Fee: \$80.30 Benefit: 75% = \$60.25 85% = \$68.30	

ATTENDANCES

OTHER NON-REFERRED

+ 697	<p>Professional attendance AT A PLACE OTHER THAN CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment - each attendance on any day of the week <i>between 11pm and 7am</i> <i>(See para A.10 of explanatory notes to this Category)</i> Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45</p>
+ 698	<p>Professional attendance AT CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms</u> for the attendance - each attendance on any day of the week between <i>11pm and 7am</i> <i>(See para A.10 of explanatory notes to this Category)</i> Fee: \$97.00 Benefit: 75% = \$72.75 85% = \$82.45</p>

GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

	SPECIALIST, REFERRED CONSULTATION - SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her)		
104	- INITIAL attendance in a single course of treatment, not being a service to which item 106 applies Fee: \$69.35	Benefit: 75% = \$52.05	85% = \$58.95
105	Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$34.80		
		Benefit: 75% = \$26.10	85% = \$29.60
106	- INITIAL ATTENDANCE in a single course of treatment, being an attendance at which refraction is performed by a specialist ophthalmologist, and the attendance results in the issuing of a prescription for spectacles or contact lenses, including any consultation on the same occasion and any other attendance on the same day (other than a service to which items 10801 to 10816 apply) Fee: \$57.15		
		Benefit: 75% = \$42.90	85% = \$48.60
	SPECIALIST, REFERRED CONSULTATION - HOME VISITS (Professional attendance at a place other than consulting rooms or hospital by a specialist in the practice of his or her specialty where the patient is referred to him or her)		
107	- INITIAL attendance in a single course of treatment Fee: \$101.70	Benefit: 75% = \$76.30	85% = \$86.45
108	Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$64.35		
		Benefit: 75% = \$48.30	85% = \$54.70

CONSULTANT PHYSICIAN		CONSULTANT PHYSICIAN	
GROUP A4 - CONSULTANT PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
	CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - SURGERY OR HOSPITAL (Professional attendance at consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)		
110	- INITIAL attendance in a single course of treatment Fee: \$122.35	Benefit: 75% = \$91.80	85% = \$104.00
116	- Each attendance (other than a service to which item 119 applies) SUBSEQUENT to the first in a single course of treatment Fee: \$61.25	Benefit: 75% = \$45.95	85% = \$52.10
119	- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.11 of explanatory notes to this Category)</i> Fee: \$34.80	Benefit: 75% = \$26.10	85% = \$29.60
	CONSULTANT PHYSICIAN (OTHER THAN IN PSYCHIATRY), REFERRED CONSULTATION - HOME VISITS (Professional attendance at a place other than consulting rooms or hospital by a consultant physician in the practice of his or her specialty (other than in psychiatry) where the patient is referred to him or her by a medical practitioner)		
122	- INITIAL attendance in a single course of treatment Fee: \$148.50	Benefit: 75% = \$111.40	85% = \$126.25
128	- Each attendance (other than a service to which item 131 applies) SUBSEQUENT to the first in a single course of treatment Fee: \$89.75	Benefit: 75% = \$67.35	85% = \$76.30
131	- Each MINOR attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.11 of explanatory notes to this Category)</i> Fee: \$64.65	Benefit: 75% = \$48.50	85% = \$55.00

GROUP A5 - PROLONGED ATTENDANCES TO WHICH NO OTHER ITEM APPLIES

PROLONGED PROFESSIONAL ATTENDANCES			
(Professional attendance (not being a service to which another item in this Category applies) on a patient in imminent danger of death requiring continuous attendance on the patient to the exclusion of all other patients)			
160	- For a period of not less than 1 hour but less than 2 hours (See para A.12 of explanatory notes to this Category)	Fee: \$176.05	Benefit: 75% = \$132.05 85% = \$149.65
161	For a period of not less than 2 hours but less than 3 hours (See para A.12 of explanatory notes to this Category)	Fee: \$293.40	Benefit: 75% = \$220.05 85% = \$249.40
162	For a period of not less than 3 hours but less than 4 hours (See para A.12 of explanatory notes to this Category)	Fee: \$410.70	Benefit: 75% = \$308.05 85% = \$353.60
163	For a period of not less than 4 hours but less than 5 hours (See para A.12 of explanatory notes to this Category)	Fee: \$528.20	Benefit: 75% = \$396.15 85% = \$471.10
164	- For a period of 5 hours or more (See para A.12 of explanatory notes to this Category)	Fee: \$586.90	Benefit: 75% = \$440.20 85% = \$529.80

GROUP THERAPY		GROUP THERAPY	
GROUP A6 - GROUP THERAPY			
FAMILY GROUP THERAPY			
	(Professional attendance for the purpose of group therapy of not less than 1 hours duration given under the direct continuous supervision of a medical practitioner, other than a consultant physician in the practice of his or her specialty of psychiatry, involving members of a family and persons with close personal relationships with that family)		
	- each group of 2 patients (See para A.13 of explanatory notes to this Category)		
170	Fee: \$93.45	Benefit: 75% = \$70.10	85% = \$79.45
	- each group of 3 patients (See para A.13 of explanatory notes to this Category)		
171	Fee: \$98.50	Benefit: 75% = \$73.90	85% = \$83.75
	- each group of 4 or more patients (See para A.13 of explanatory notes to this Category)		
172	Fee: \$119.80	Benefit: 75% = \$89.85	85% = \$101.85

ACUPUNCTURE	ACUPUNCTURE
GROUP A7 - ACUPUNCTURE	
173	<p>ATTENDANCE at which ACUPUNCTURE is performed by a medical practitioner by application of stimuli on or through the surface of the skin by any means, including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed <i>(See para A.14 of explanatory notes to this Category)</i></p> <p>Fee: \$21.65 Benefit: 75% = \$16.25 85% = \$18.45</p>
193	<p>Professional attendance by a general practitioner at a place other than a hospital, involving either:</p> <p>(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR</p> <p>(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies</p> <p>AND at which ACUPUNCTURE is performed by the medical practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed <i>(See para A.5 and A.14 of explanatory notes to this Category)</i></p> <p>Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05</p>
195	<p>Professional attendance by a general practitioner on 1 or more patients at a hospital, on one occasion, involving either:</p> <p>(i) taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems; OR</p> <p>(ii) a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies</p> <p>AND at which ACUPUNCTURE is performed by the medical practitioner by the application of stimuli on or through the surface of the skin by any means; including any consultation on the same occasion and any other attendance on the same day related to the condition for which the acupuncture was performed <i>(See para A.5 and A.14 of explanatory notes to this Category)</i></p> <p>Derived Fee: The fee for item 193, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 193 plus \$1.45 per patient</p>

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST
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)	
300	- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300 , 302 , 304 , 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year. Fee: \$35.10	Benefit: 75% = \$26.35 85% = \$29.85
302	- 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 item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year. Fee: \$70.15	Benefit: 75% = \$52.65 85% = \$59.65
304	- 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 item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year. Fee: \$102.80	Benefit: 75% = \$77.10 85% = \$87.40
306	- 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 item 300, 302, 304, 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year. Fee: \$141.90	Benefit: 75% = \$106.45 85% = \$120.65
308	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300 , 302 , 304 , 306 or 308 apply have not exceeded the sum of 50 attendances in a calendar year. Fee: \$172.85	Benefit: 75% = \$129.65 85% = \$146.95
310	- An attendance of not more than 15 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300 , 302 , 304 , 306 , 308 , 310 , 312 , 314 , 316 or 318 apply exceed 50 attendances in a calendar year. Fee: \$17.55	Benefit: 75% = \$13.20 85% = \$14.95
312	- 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 item 300 , 302 , 304 , 306 , 308 , 310 , 312 , 314 , 316 or 318 apply exceed 50 attendances in a calendar year. Fee: \$35.10	Benefit: 75% = \$26.35 85% = \$29.85
314	- 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 item 300 , 302 , 304 , 306 , 308 , 310 , 312 , 314 , 316 or 318 apply exceed 50 attendances in a calendar year. Fee: \$51.40	Benefit: 75% = \$38.55 85% = \$43.70
316	- 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 item 300 , 302 , 304 , 306 , 308 , 310 , 312 , 314 , 316 or 318 apply exceed 50 attendances in a calendar year. Fee: \$71.00	Benefit: 75% = \$53.25 85% = \$60.35
318	- An attendance of more than 75 minutes duration at consulting rooms, where that attendance and any other attendance to which item 300 , 302 , 304 , 306 , 308 , 310 , 312 , 314 , 316 or 318 apply exceed 50 attendances in a calendar year. Fee: \$86.50	Benefit: 75% = \$64.90 85% = \$73.55
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.15 of explanatory notes to this Category) Fee: \$141.90	Benefit: 75% = \$106.45 85% = \$120.65

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOSPITAL

(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)

320 - An attendance of not more than 15 minutes duration at hospital.
Fee: \$35.10 **Benefit:** 75% = \$26.35 85% = \$29.85

322 - An attendance of more than 15 minutes duration but not more than 30 minutes duration at hospital
Fee: \$70.15 **Benefit:** 75% = \$52.65 85% = \$59.65

324 - An attendance of more than 30 minutes duration but not more than 45 minutes duration at hospital
Fee: \$102.80 **Benefit:** 75% = \$77.10 85% = \$87.40

326 - An attendance of more than 45 minutes duration but not more than 75 minutes duration at hospital
Fee: \$141.90 **Benefit:** 75% = \$106.45 85% = \$120.65

328 - An attendance of more than 75 minutes duration at hospital **Fee:**
\$172.85 **Benefit:** 75% = \$129.65 85% = \$146.95

CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION, HOME VISITS

(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)

330 - An attendance of not more than 15 minutes duration where that attendance is at a place other than consulting rooms or hospital
Fee: \$64.45 **Benefit:** 75% = \$48.35 85% = \$54.80

332 - An attendance of more than 15 minutes duration but not more than 30 minutes duration where that attendance is at a place other than consulting rooms or hospital
Fee: \$101.10 **Benefit:** 75% = \$75.85 85% = \$85.95

334 - An attendance of more than 30 minutes duration but not more than 45 minutes duration where that attendance is at a place other than consulting rooms or hospital
Fee: \$140.25 **Benefit:** 75% = \$105.20 85% = \$119.25

336 - An attendance of more than 45 minutes duration but not more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital
Fee: \$169.70 **Benefit:** 75% = \$127.30 85% = \$144.25

338 - An attendance of more than 75 minutes duration where that attendance is at a place other than consulting rooms or hospital
Fee: \$202.30 **Benefit:** 75% = \$151.75 85% = \$172.00

CONSULTANT PSYCHIATRIST - GROUP PSYCHOTHERAPY

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

342 - GROUP PSYCHOTHERAPY on a group of 2 to 9 unrelated patients OR FAMILY GROUP psychotherapy on a group of more than 3 patients, EACH PATIENT
Fee: \$40.00 **Benefit:** 75% = \$30.00 85% = \$34.00

344 - FAMILY GROUP PSYCHOTHERAPY on a group of 3 patients, EACH PATIENT
Fee: \$53.10 **Benefit:** 75% = \$39.85 85% = \$45.15

346 - FAMILY GROUP PSYCHOTHERAPY on a group of 2 patients, EACH PATIENT
Fee: \$78.50 **Benefit:** 75% = \$58.90 85% = \$66.75

348	<p>CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY</p> <p>Professional attendance by a consultant physician in the practice of his or her recognised specialty of psychiatry, where the patient is referred to him or her by a medical practitioner involving an interview of a person other than the patient of not less than 20 minutes duration but less than 45 minutes duration, in the course of initial diagnostic evaluation of a patient, where that interview is at consulting rooms, hospital or residential aged care facility (See para A.16 of explanatory notes to this Category)</p> <p>Fee: \$42.45 Benefit: 75% = \$31.85 85% = \$36.10</p>
350	<p>- An attendance of not less than 45 minutes duration (See para A.16 of explanatory notes to this Category) Fee: \$95.40 Benefit: 75% = \$71.55 85% = \$81.10</p>
352	<p>CONSULTANT PSYCHIATRIST - INTERVIEW OF A PERSON OTHER THAN A PATIENT - IN THE COURSE OF CONTINUING MANAGEMENT OF A PATIENT</p> <p>Professional attendance by a consultant physician in the practice of his or her specialty of psychiatry, where the patient is referred to him or her by a medical practitioner, involving an interview of a person other than the patient of not less than 20 minutes duration, in the course of continuing management of a patient - payable not more than 4 times in any 12 month period (See para A.16 of explanatory notes to this Category)</p> <p>Fee: \$42.45 Benefit: 75% = \$31.85 85% = \$36.10</p>

CONSULT OCCUPATIONAL PHYSICIAN		CONSULT OCCUPATIONAL PHYSICIAN	
GROUP A12 - CONSULTANT OCCUPATIONAL PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
	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)		
385	-INITIAL attendance in a single course of treatment <i>(See para A.17 of explanatory notes to this Category)</i> Fee: \$69.35	Benefit: 75% = \$52.05	85% = \$58.95
386	- Each attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.17 of explanatory notes to this Category)</i> Fee: \$34.80	Benefit: 75% = \$26.10	85% = \$29.60
	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)		
387	- INITIAL attendance in a single course of treatment <i>(See para A.17 of explanatory notes to this Category)</i> Fee: \$101.70	Benefit: 75% = \$76.30	85% = \$86.45
388	- Each attendance SUBSEQUENT to the first in a single course of treatment <i>(See para A.17 of explanatory notes to this Category)</i> Fee: \$64.35	Benefit: 75% = \$48.30	85% = \$54.70

PUBLIC HEALTH		PUBLIC HEALTH
GROUP A13 - PUBLIC HEALTH PHYSICIAN ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
PUBLIC HEALTH PHYSICIAN ATTENDANCES - SURGERY		
(Professional attendance at consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)		
410	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.23 of explanatory notes to this Category) Fee: \$13.45	Benefit: 75% = \$10.10 85% = \$11.45
411	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 412 applies (See para A.23 of explanatory notes to this Category) Fee: \$29.45	Benefit: 75% = \$22.10 85% = \$25.05
412	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 413 applies (See para A.23 of explanatory notes to this Category) Fee: \$55.95	Benefit: 75% = \$42.00 85% = \$47.60
413	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan (See para A.23 of explanatory notes to this Category) Fee: \$82.40	Benefit: 75% = \$61.80 85% = \$70.05
PUBLIC HEALTH PHYSICIAN ATTENDANCES - OTHER THAN AT CONSULTING ROOMS		
(Professional attendance at other than consulting rooms by a public health physician in the practice of his or her specialty of public health medicine)		
414	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.23 of explanatory notes to this Category) Derived Fee: The fee for item 410 , plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 410 plus \$1.45 per patient	
415	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, OR an attendance of less than 20 minutes duration involving components of a service to which item 416 applies (See para A.23 of explanatory notes to this Category) Derived Fee: The fee for item 411 , plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 411 plus \$1.45 per patient	
416	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, OR an attendance of less than 40 minutes duration involving components of a service to which item 417 applies (See para A.23 of explanatory notes to this Category) Derived Fee: The fee for item 412 , plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 412 plus \$1.45 per patient	
417	- Attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR an attendance of at least 40 minutes duration for implementation of a management plan (See para A.23 of explanatory notes to this Category) Derived Fee: The fee for item 413 , plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 413 plus \$1.45 per patient	

ATTENDANCES		MEDICAL PRACTITIONER - SPORTS	
	GROUP A16 - MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES		
	SUBGROUP 1 - SURGERY CONSULTATIONS		
	MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES - SURGERY		
	LEVEL 1		
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	- Attendance for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management (See para A.25 of explanatory notes to this Category)		
444	Fee: \$13.45	Benefit: 75% = \$10.10	85% = \$11.45
	LEVEL 2		
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	- Attendance involving taking a selective history, examination of the patient with implementation of a management plan in relation to 1 or more problems, or an attendance of less than 20 minutes duration involving components of a service to which item 446 applies (See para A.25 of explanatory notes to this Category)		
445	Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
	LEVEL 3		
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	- Attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more problems, and lasting at least 20 minutes, or an attendance of less than 40 minutes duration involving components of a service to which item 447 applies (See para A.25 of explanatory notes to this Category)		
446	Fee: \$55.95	Benefit: 75% = \$42.00	85% = \$47.60
	LEVEL 4		
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	- Attendance involving taking an exhaustive history, an comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, or an attendance of at least 40 minutes duration for implementation of a management plan (See para A.25 of explanatory notes to this Category)		
447	Fee: \$82.40	Benefit: 75% = \$61.80	85% = \$70.05
	SUBGROUP 2 - EMERGENCY ATTENDANCES - AFTER HOURS		
	MEDICAL PRACTITIONER (SPORTS PHYSICIAN) ATTENDANCES - EMERGENCY AFTER HOURS		
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	Professional attendance AT CONSULTING ROOMS where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance <i>other than an attendance between 11pm and 7am</i>, on a public holiday, on a Sunday, before 8am or after 1pm on a Saturday, or at any time other than between 8am and 8pm on a day not being a Saturday, Sunday or public holiday</u> (See para A.10 of explanatory notes to this Category)		
448	Fee: \$93.70	Benefit: 75% = \$70.30	85% = \$79.65
	Professional attendance at consulting rooms by a medical practitioner who is a sports physician in the practice of sports medicine		
	Professional attendance, AT CONSULTING ROOMS , where the attendance is initiated by or on behalf of the patient in the same unbroken after hours period and where the patient's medical condition requires immediate treatment and <u>where it is necessary for the doctor to return to, and specially open, consulting rooms for the attendance - each attendance on any day of the week between 11pm and 7am</u> (See para A.10 of explanatory notes to this Category)		
449	Fee: \$112.05	Benefit: 75% = \$84.05	85% = \$95.25

MEDICAL PRACTITIONER		EMERGENCY MEDICINE	
GROUP A21 - MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
SUBGROUP 1 - CONSULTATIONS			
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES - EMERGENCY DEPARTMENT LEVEL 1			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of a problem focussed history, limited examination, diagnosis and initiation of appropriate treatment interventions involving straightforward medical decision making. <i>(See para A.33 of explanatory notes to this Category)</i>			
501	Fee: \$13.45	Benefit: 75% = \$10.10	85% = \$11.45
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES - EMERGENCY DEPARTMENT LEVEL 2			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency medicine physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems and the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of low complexity. <i>(See para A.33 of explanatory notes to this Category)</i>			
503	Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES - EMERGENCY DEPARTMENT LEVEL 3			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of an expanded problem focussed history, expanded examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, and the initiation of appropriate treatment interventions involving medical decision making of moderate complexity. <i>(See para A.33 of explanatory notes to this Category)</i>			
507	Fee: \$55.95	Benefit: 75% = \$42.00	85% = \$47.60
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES - EMERGENCY DEPARTMENT LEVEL 4			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of a detailed history, detailed examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of moderate complexity. <i>(See para A.33 of explanatory notes to this Category)</i>			
511	Fee: \$82.40	Benefit: 75% = \$61.80	85% = \$70.05
MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES - EMERGENCY DEPARTMENT LEVEL 5			
Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine			
Attendance for the unscheduled evaluation and management of a patient requiring the taking of a comprehensive history, comprehensive examination of one or more systems, ordering and evaluation of appropriate investigations, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives, involving medical decision making of high complexity. <i>(See para A.33 of explanatory notes to this Category)</i>			
515	Fee: \$131.80	Benefit: 75% = \$98.85	85% = \$112.05

SUBGROUP 2 - PROLONGED PROFESSIONAL ATTENDANCES TO WHICH NO OTHER GROUP APPLIES

MEDICAL PRACTITIONER (EMERGENCY PHYSICIAN) ATTENDANCES - EMERGENCY DEPARTMENT

Professional attendance on a patient at a recognised emergency department of a private hospital by a medical practitioner who is an emergency physician in the practice of emergency medicine

Attendance for emergency evaluation of a critically ill patient with an immediately life threatening problem requiring immediate and rapid assessment, initiation of resuscitation and electronic vital signs monitoring, comprehensive history and evaluation whilst undertaking resuscitative measures, ordering and evaluation of appropriate investigations, transitional evaluation and monitoring, the formulation and documentation of a diagnosis and management plan in relation to one or more problems, the initiation of appropriate treatment interventions, liaison with relevant health care professionals and discussion with the patient, his/her agent/s and/or relatives prior to admission to an in-patient hospital bed

-For a period of not less than 30 minutes but less than 1 hours of total physician time spent with each patient (See

para A.34 of explanatory notes to this Category)

519

Fee: \$88.00

Benefit: 75% = \$66.60

85% = \$74.80

-For a period of not less than 1 hour but less than 2 hours of total physician time spent with each patient (See *para A.34 of explanatory notes to this Category)*

520

Fee: \$176.05

Benefit: 75% = \$132.05

85% = \$149.65

-For a period of not less than 2 hours but less than 3 hours of total physician time spent with each patient (See *para A.34 of explanatory notes to this Category)*

530

Fee: \$293.40

Benefit: 75% = \$220.05

85% = \$249.40

-For a period of not less than 3 hours but less than 4 hours of total physician time spent with each patient. (See *para A.34 of explanatory notes to this Category)*

532

Fee: \$410.70

Benefit: 75% = \$308.05

85% = \$353.60

-For a period of not less than 4 hours but less than 5 hours of total physician time spent with each patient (See *para A.34 of explanatory notes to this Category)*

534

Fee: \$528.20

Benefit: 75% = \$396.15

85% = \$471.10

-For a period of 5 hours or more of total physician time spent with each patient. (See *para A.34 of explanatory notes to this Category)*

536

Fee: \$586.90

Benefit: 75% = \$440.20

85% = \$529.80

GROUP A14 - HEALTH ASSESSMENTS

700	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) AT CONSULTING ROOMS for a health assessment - of a patient who is at least 75 years old - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 702, 704 or 706 <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$153.65 Benefit: 75% = \$115.25 85% = \$130.65</p>
702	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY for a health assessment - of a patient who is at least 75 years old - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 700, 704 or 706 <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$217.30 Benefit: 75% = \$163.00 85% = \$184.75</p>
704	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) AT CONSULTING ROOMS for a health assessment - of a patient who is at least 55 years old and of Aboriginal or Torres Strait Islander descent - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 700, 702 or 706 <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$153.65 Benefit: 75% = \$115.25 85% = \$130.65</p>
706	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) NOT BEING AN ATTENDANCE AT CONSULTING ROOMS, A HOSPITAL OR A RESIDENTIAL AGED CARE FACILITY, for a health assessment - of a patient who is at least 55 years old and of Aboriginal or Torres Strait Islander descent - not being a health assessment of a patient in respect of whom, in the preceding 12 months, a payment has been made under this item or item 700, 702 or 704 <i>(See para A.20 of explanatory notes to this Category)</i> Fee: \$217.30 Benefit: 75% = \$163.00 85% = \$184.75</p>

GROUP A15 - MULTIDISCIPLINARY CARE PLANS AND CASE CONFERENCES

SUBGROUP 1 - MULTIDISCIPLINARY CARE PLANS

720	<p>PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary COMMUNITY CARE PLAN for a patient (not being a service associated with a service to which items 734 to 779 apply) - payable not more than once in any 6 month period (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</p>
722	<p>PREPARATION by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), in consultation with a multidisciplinary care plan team, of a multidisciplinary DISCHARGE CARE PLAN for a patient (not being a service associated with a service to which items 734 to 779 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$197.55 Benefit: 75% = \$148.20 85% = \$167.95</p>
724	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), to REVIEW a multidisciplinary COMMUNITY CARE PLAN or a DISCHARGE CARE PLAN prepared by that medical practitioner for a patient and claimed for under item 720 or 722 (not being a payment for a service to which items 734 to 779 apply) - payable not more than once in any 3 month period, and not being an attendance in relation to a patient: (a) for whom, in the preceding 3 months, a payment has been made under item 720; or (b) for whom, in the preceding month, a payment has been made under item 722 (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$98.80 Benefit: 75% = \$74.10 85% = \$84.00</p>
726	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to contribute to a multidisciplinary COMMUNITY CARE PLAN or to a REVIEW of a multidisciplinary COMMUNITY CARE PLAN prepared by another provider (not being a payment for a service to which items 734 to 779 apply) - not being an attendance in relation to a patient for whom, in the preceding 6 months, a payment has been made under item 720 (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$39.80 Benefit: 75% = \$29.85 85% = \$33.85</p>
728	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to CONTRIBUTE to a multidisciplinary DISCHARGE CARE PLAN or to a REVIEW of a multidisciplinary DISCHARGE CARE PLAN prepared by another provider (not being a service associated with a service to which items 722, 734 to 779 apply) (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$39.80 Benefit: 75% = \$29.85 85% = \$33.85</p>
730	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a multidisciplinary care plan team, to make a CONTRIBUTION to a multidisciplinary CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY or to a REVIEW of a multidisciplinary CARE PLAN IN A RESIDENTIAL AGED CARE FACILITY prepared by the residential aged care facility (not being a payment in respect of a service to which items 734 to 779 apply) (See para A.21 of explanatory notes to this Category)</p> <p>Fee: \$39.80 Benefit: 75% = \$29.85 85% = \$33.85</p>
SUBGROUP 2 - CASE CONFERENCES	
CASE CONFERENCE - MEDICAL PRACTITIONER (OTHER THAN A SPECIALIST OR CONSULTANT PHYSICIAN)	
734	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which item 730 applies) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$76.90 Benefit: 75% = \$57.70 85% = \$65.40</p>
736	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which item 730 applies) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$115.25 Benefit: 75% = \$86.45 85% = \$98.00</p>

MULTIDISCIPLINARY CARE PLANS

CASE CONFERENCES

738	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY, where the conference time is at least 45 minutes, (not being a service associated with a service to which item 730 applies) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$153.65 Benefit: 75% = \$115.25 85% = \$130.65</p>
740	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which items 720 to 730 apply) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$76.90 Benefit: 75% = \$57.70 85% = \$65.40</p>
742	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which items 720 to 730 apply) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$115.25 Benefit: 75% = \$86.45 85% = \$98.00</p>
744	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE, where the conference time is at least 45 minutes (not being a service associated with a service to which items 720 to 730 apply) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$153.65 Benefit: 75% = \$115.25 85% = \$130.65</p>
746	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which items 720 to 730 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$76.90 Benefit: 75% = \$57.70 85% = \$65.40</p>
749	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which items 720 to 730 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$115.25 Benefit: 75% = \$86.45 85% = \$98.00</p>
757	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE, where the conference time is at least 45 minutes (not being a service associated with a service to which items 720 to 730 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$153.65 Benefit: 75% = \$115.25 85% = \$130.65</p>
759	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE, (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which items 720 to 730 apply) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$54.85 Benefit: 75% = \$41.15 85% = \$46.65</p>
762	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which items 720 to 730 apply) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$87.80 Benefit: 75% = \$65.85 85% = \$74.65</p>
765	<p>Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which items 720 to 730 apply) (See para A.22 of explanatory notes to this Category)</p> <p>Fee: \$120.70 Benefit: 75% = \$90.55 85% = \$102.60</p>

MULTIDISCIPLINARY CARE PLANS		CASE CONFERENCES	
768	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which items 720 to 730 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.22 of explanatory notes to this Category)	Fee: \$54.85	Benefit: 75% = \$41.15 85% = \$46.65
771	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which items 720 to 730 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.22 of explanatory notes to this Category)	Fee: \$87.80	Benefit: 75% = \$65.85 85% = \$74.65
773	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes (not being a service associated with a service to which items 720 to 730 apply) - payable not more than once for each HOSPITAL ADMISSION (See para A.22 of explanatory notes to this Category)	Fee: \$120.70	Benefit: 75% = \$90.55 85% = \$102.60
775	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY , (other than to organise and co-ordinate the conference), where the conference time is at least 15 minutes, but less than 30 minutes (not being a service associated with a service to which item 730 applies) (See para A.22 of explanatory notes to this Category)	Fee: \$54.85	Benefit: 75% = \$41.15 85% = \$46.65
778	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY , (other than to organise and co-ordinate the conference), where the conference time is at least 30 minutes, but less than 45 minutes (not being a service associated with a service to which item 730 applies) (See para A.22 of explanatory notes to this Category)	Fee: \$87.80	Benefit: 75% = \$65.85 85% = \$74.65
779	Attendance by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician), as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE IN A RESIDENTIAL AGED CARE FACILITY , (other than to organise and co-ordinate the conference), where the conference time is at least 45 minutes, (not being a service associated with a service to which item 730 applies) (See para A.22 of explanatory notes to this Category)	Fee: \$120.70	Benefit: 75% = \$90.55 85% = \$102.60
CASE CONFERENCE - CONSULTANT PHYSICIAN			
820	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) (See para A.24 of explanatory notes to this Category)	Fee: \$112.75	Benefit: 75% = \$84.60 85% = \$95.85
822	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) (See para A.24 of explanatory notes to this Category)	Fee: \$169.15	Benefit: 75% = \$126.90 85% = \$143.80
823	Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A COMMUNITY CASE CONFERENCE of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) (See para A.24 of explanatory notes to this Category)	Fee: \$225.50	Benefit: 75% = \$169.15 85% = \$191.70

825	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$81.00 Benefit: 75% = \$60.75 85% = \$68.85</p>
826	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$129.15 Benefit: 75% = \$96.90 85% = \$109.80</p>
828	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A COMMUNITY CASE CONFERENCE (other than to organise and to coordinate the conference) of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$177.35 Benefit: 75% = \$133.05 85% = \$150.75</p>
830	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$112.75 Benefit: 75% = \$84.60 85% = \$95.85</p>
832	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$169.15 Benefit: 75% = \$126.90 85% = \$143.80</p>
834	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to ORGANISE AND COORDINATE A DISCHARGE CASE CONFERENCE of at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$225.50 Benefit: 75% = \$169.15 85% = \$191.70</p>
835	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE of at least 15 minutes but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$81.00 Benefit: 75% = \$60.75 85% = \$68.85</p>
837	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE of at least 30 minutes but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$129.15 Benefit: 75% = \$96.90 85% = \$109.80</p>
838	<p>Attendance by a consultant physician in the practice of his or her specialty, as a member of a case conference team, to PARTICIPATE IN A DISCHARGE CASE CONFERENCE of at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines (see note A24.7 on permissible combinations) <i>(See para A.24 of explanatory notes to this Category)</i></p> <p>Fee: \$177.35 Benefit: 75% = \$133.05 85% = \$150.75</p>
855	<p style="text-align: center;">CASE CONFERENCE - CONSULTANT PSYCHIATRIST</p> <p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.35 of explanatory notes to this Category)</i></p> <p>Fee: \$112.75 Benefit: 75% = \$84.60 85% = \$95.85</p>

MULTIDISCIPLINARY CARE PLANS	CASE CONFERENCES
857	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$169.15 Benefit: 75% = \$126.90 85% = \$143.80</p>
858	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND CO-ORDINATE A COMMUNITY CASE CONFERENCE of at least 45 minutes with a multidisciplinary team of at least two other formal care providers, of different disciplines <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$225.50 Benefit: 75% = \$169.10 85% = \$191.65</p>
861	<p style="text-align: center;">CASE CONFERENCE - CONSULTANT PSYCHIATRIST</p> <p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE, of at least 15 minutes, but less than 30 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$112.75 Benefit: 75% = \$84.60 85% = \$95.85</p>
864	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE, of at least 30 minutes, but less than 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$169.15 Benefit: 75% = \$126.90 85% = \$143.80</p>
866	<p>Attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, as a member of a case conference team, to ORGANISE AND CO-ORDINATE A DISCHARGE CASE CONFERENCE, of at least 45 minutes with a multidisciplinary team of at least two other formal care providers of different disciplines <i>(See para A.35 of explanatory notes to this Category)</i> Fee: \$225.50 Benefit: 75% = \$169.10 85% = \$191.65</p>

GROUP A17 - DOMICILIARY MEDICATION MANAGEMENT REVIEW	
900	<p>Participation by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician) in a Domiciliary Medication Management Review (DMMR) for patients living in the community setting, where the medical practitioner:</p> <ul style="list-style-type: none"> - assesses a patient's medication management needs, and following that assessment, refers the patient to a community pharmacy for a DMMR, and provides relevant clinical information required for the review, with the patient's consent; and - discusses with the reviewing pharmacist the results of that review including suggested medication management strategies; and - develops a written medication management plan following discussion with the patient. <p>Benefits under this item are payable not more than once in each 12 month period, except where there has been a significant change in the patient's condition or medication regimen requiring a new DMMR. (See para A.26 of explanatory notes to this Category)</p> <p>Fee: \$123.00 Benefit: 75% = \$92.25 85% = \$104.55</p>

INCENTIVE ITEMS	GENERAL PRACTITIONER																								
	<p align="center">SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH DIABETES MELLITUS</p> <p>Note: Benefits are payable for only one service included in Subgroup 2 or A19, Subgroup 2 in a 12-month period</p> <p>The minimum requirements of care needed to be assessed to complete an annual cycle of care for patients with diabetes mellitus are:</p> <table border="0"> <tr> <td>- Assess diabetes control by measuring HbA_{1c}</td> <td>At least once every year</td> </tr> <tr> <td>- Ensure that a comprehensive eye examination is carried out:</td> <td>At least once every two years</td> </tr> <tr> <td>- Measure weight and height and calculate BMI*:</td> <td>At least once every six months</td> </tr> <tr> <td>- Measure blood pressure:</td> <td>At least once every six months</td> </tr> <tr> <td>- Examine feet:</td> <td>At least once every six months</td> </tr> <tr> <td>- Measure total cholesterol, triglycerides and HDL cholesterol:</td> <td>At least once every year</td> </tr> <tr> <td>- Test for microalbuminuria:</td> <td>At least once every year</td> </tr> <tr> <td>- Provide self-care education:</td> <td>Patient education regarding diabetes management</td> </tr> <tr> <td>- Review diet:</td> <td>Reinforce information about appropriate dietary choices</td> </tr> <tr> <td>- Review levels of physical activity:</td> <td>Reinforce information about appropriate levels of physical activity</td> </tr> <tr> <td>- Check smoking status:</td> <td>Encourage cessation of smoking (if relevant)</td> </tr> <tr> <td>- Review of medication:</td> <td>Medication review</td> </tr> </table> <p>* Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight.</p> <p>LEVEL 'B' Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36, 37, 38, 40, 43, 44, 47, 48, 50 or 51 applies;</p> <p>AND which <u>completes</u> the requirements for a full year of care of a patient with established diabetes mellitus</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.28 of explanatory notes to this Category)</p> <p>2517 Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05</p>	- Assess diabetes control by measuring HbA _{1c}	At least once every year	- Ensure that a comprehensive eye examination is carried out:	At least once every two years	- Measure weight and height and calculate BMI*:	At least once every six months	- Measure blood pressure:	At least once every six months	- Examine feet:	At least once every six months	- Measure total cholesterol, triglycerides and HDL cholesterol:	At least once every year	- Test for microalbuminuria:	At least once every year	- Provide self-care education:	Patient education regarding diabetes management	- Review diet:	Reinforce information about appropriate dietary choices	- Review levels of physical activity:	Reinforce information about appropriate levels of physical activity	- Check smoking status:	Encourage cessation of smoking (if relevant)	- Review of medication:	Medication review
- Assess diabetes control by measuring HbA _{1c}	At least once every year																								
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- Review levels of physical activity:	Reinforce information about appropriate levels of physical activity																								
- Check smoking status:	Encourage cessation of smoking (if relevant)																								
- Review of medication:	Medication review																								
2518	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 2517, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2517 plus \$1.45 per patient</p>																								
2521	<p align="center">LEVEL 'C'</p> <p>Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44, 47, 48, 50 or 51 applies;</p> <p>AND which <u>completes</u> the requirements for a full year of care of a patient with established diabetes mellitus</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.28 of explanatory notes to this Category)</p> <p>2521 Fee: \$55.95 Benefit: 75% = \$42.00 85% = \$47.60</p>																								
2522	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: The fee for item 2521, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2521 plus \$1.45 per patient</p>																								

	LEVEL 'D'
	Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more complex problems and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan; AND which <u>completes</u> the requirements for a full year of care of a patient with established diabetes mellitus
	SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.28 of explanatory notes to this Category)
2525	Fee: \$82.40 Benefit: 75% = \$61.80 85% = \$70.05
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) (See para A.28 of explanatory notes to this Category)
2526	Derived Fee: The fee for item 2525 , plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for 2525 plus \$1.45 per patient
	SUBGROUP 3 - COMPLETION OF THE ASTHMA 3+ VISIT PLAN
	Note: Benefits are payable for only one service included in Subgroup 3 or A19, Subgroup 3 in a 12-month period, unless a further Asthma 3+ Visit Plan is clinically indicated.
	At a minimum the Asthma 3+ Visit Plan must include: - documented diagnosis and assessment of severity - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma - review of the patient's use of asthma related medication - planned recalls for at least two of these consultations - provision of a written asthma action plan and self-management education to the patient, (if the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record). - review of asthma action plan
	LEVEL 'B'
	Professional attendance involving taking a selective history, examination of the patient with the implementation of a management plan in relation to one or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service to which item 36 , 37 , 38 , 40 , 43 , 44 , 47 , 48 , 50 or 51 applies; AND which <u>completes</u> the minimum requirements of the Asthma 3+ Visit Plan.
	SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.29 of explanatory notes to this Category)
2546	Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05
	OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) (See para A.29 of explanatory notes to this Category)
2547	Derived Fee: The fee for item 2546 , plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2546 plus \$1.45 per patient
	LEVEL 'C'
	Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems and lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration involving components of a service to which item 44 , 47 , 48 , 50 or 51 applies; AND which <u>completes</u> the minimum requirements of the Asthma 3+ Visit Plan.
	SURGERY CONSULTATION (Professional attendance at consulting rooms) (See para A.29 of explanatory notes to this Category)
2552	Fee: \$55.95 Benefit: 75% = \$42.00 85% = \$47.60

2577	<p style="text-align: center;">LEVEL 'D'</p> <p>Professional attendance involving taking an exhaustive history, a comprehensive examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to 1 or more complex problems, and lasting at least 40 minutes, OR a professional attendance of at least 40 minutes duration for implementation of a management plan;</p> <p>AND which <u>completes</u> the requirements of the 3 Step Mental Health Process.</p> <p>SURGERY CONSULTATION (Professional attendance at consulting rooms)</p> <p>Fee: \$82.40 Benefit: 75% = \$61.80 85% = \$70.05</p>
2578	<p>OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms)</p> <p>Derived Fee: The fee for item 2577, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2578 plus \$1.45 per patient.</p>

INCENTIVE ITEMS	OTHER NON-REFERRED
<p align="center">GROUP A19 - OTHER NON-REFERRED ATTENDANCES ASSOCIATED WITH PIP INCENTIVE PAYMENTS TO WHICH NO OTHER ITEM APPLIES</p>	
<p align="center">SUBGROUP 1 - TAKING OF A CERVICAL SMEAR FROM AN UNSCREENED OR SIGNIFICANTLY UNDERSCREENED WOMAN</p>	
<p align="center">SURGERY CONSULTATIONS</p>	
2600	<p>(Professional attendance at consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years <i>(See para A.27 of explanatory notes to this Category)</i></p> <p>Fee: \$21.00 Benefit: 75% = \$15.75 85% = \$17.85</p>
2603	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years <i>(See para A.27 of explanatory notes to this Category)</i></p> <p>Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30</p>
2606	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive who has not had a cervical smear in the last 4 years <i>(See para A.27 of explanatory notes to this Category)</i></p> <p>Fee: \$61.00 Benefit: 75% = \$45.75 85% = \$51.85</p>
<p align="center">OUT-OF-SURGERY CONSULTATIONS</p>	
2610	<p>(Professional attendance at a place other than consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years <i>(See para A.27 of explanatory notes to this Category)</i></p> <p>Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$0.70 per patient</p>
2613	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear in the last 4 years <i>(See para A.27 of explanatory notes to this Category)</i></p> <p>Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$0.70 per patient</p>
2616	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND at which a cervical smear is taken from a woman between the ages of 20 and 69 inclusive who has not had a cervical smear in the last 4 years <i>(See para A.27 of explanatory notes to this Category)</i></p> <p>Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$0.70 per patient</p>

SUBGROUP 2 - COMPLETION OF AN ANNUAL CYCLE OF CARE FOR PATIENTS WITH DIABETES MELLITUS	
	<p>Note: Benefits are payable for only one service included in Subgroup 2 or A18, Subgroup 2 in a 12-month period</p> <p>The minimum requirements of care needed to be assessed to complete an annual cycle of care for patients with diabetes mellitus are:</p> <ul style="list-style-type: none"> - Assess diabetes control by measuring HbA_{1c}: At least once every year - Ensure that a comprehensive eye examination is carried out: At least once every two years - Measure weight and height and calculate BMI*: At least once every six months - Measure blood pressure: At least once every six months - Examine feet: At least once every six months - Measure total cholesterol, triglycerides and HDL cholesterol: At least once every year - Test for microalbuminuria: At least once every year - Provide self-care education: Patient education regarding diabetes management - Review diet: Reinforce information about appropriate dietary choices - Review levels of physical activity: Reinforce information about appropriate levels of physical activity - Check smoking status: Encourage cessation of smoking (if relevant) - Review of medication: Medication review <p>* Initial visit: measure height and weight and calculate BMI as part of the initial patient assessment. Subsequent visits: measure weight.</p> <p>SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which completes the requirements for a full year of care of a patient with established diabetes mellitus (See para A.28 of explanatory notes to this Category)</p> <p>2620 Fee: \$21.00 Benefit: 75% = \$15.75 85% = \$17.85</p>
	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which completes the requirements for a full year of care of a patient with established diabetes mellitus (See para A.28 of explanatory notes to this Category)</p> <p>2622 Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30</p>
	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which completes the requirements for a full year of care of a patient with established diabetes mellitus (See para A.28 of explanatory notes to this Category)</p> <p>2624 Fee: \$61.00 Benefit: 75% = \$45.75 85% = \$51.85</p>
	<p style="text-align: center;">OUT-OF-SURGERY CONSULTATIONS</p> <p>(Professional attendance at a place other than the consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which completes the requirements for a full year of care of a patient with established diabetes mellitus (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$0.70 per patient</p> <p>2631</p>

INCENTIVE ITEMS	OTHER NON-REFERRED
2633	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which completes the requirements for a full year of care of a patient with established diabetes mellitus (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$35.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$35.50 plus \$0.70 per patient</p>
2635	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which completes the requirements for a full year of care of a patient with established diabetes mellitus (See para A.28 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$57.50, plus \$15.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$57.50 plus \$0.70 per patient</p>
SUBGROUP 3 - COMPLETION OF THE ASTHMA 3+ VISIT PLAN	
2664	<p>Note: Benefits are payable for only one service included in Subgroup 3 or A18, Subgroup 3 in a 12-month period, unless a further Asthma 3+ Visit Plan is clinically indicated.</p> <p>At a minimum the Asthma 3+ Visit Plan must include:</p> <ul style="list-style-type: none"> - documented diagnosis and assessment of severity - at least 3 asthma related consultations in the previous 4 weeks (minimum) to 4 months (maximum) for a patient with moderate to severe asthma - review of the patient's use of asthma related medication - planned recalls for at least two of these consultations - provision of a written asthma action plan and self-management education to the patient, (if the patient is unable to use a written action plan, alternative patient education may be provided and documented in the medical record) - review of asthma action plan <p>SURGERY CONSULTATIONS</p> <p>(Professional attendance at consulting rooms)</p> <p>STANDARD CONSULTATIONS of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which completes the minimum requirements of the Asthma 3+ Visit Plan. (See para A.29 of explanatory notes to this Category)</p> <p>Fee: \$21.00 Benefit: 75% = \$15.75 85% = \$17.85</p>
2666	<p>LONG CONSULTATION of more than 25 minutes duration but not more than 45 minutes duration</p> <p>AND which completes the minimum requirements of the Asthma 3+ Visit Plan. (See para A.29 of explanatory notes to this Category)</p> <p>Fee: \$38.00 Benefit: 75% = \$28.50 85% = \$32.30</p>
2668	<p>PROLONGED CONSULTATION of more than 45 minutes duration</p> <p>AND which completes the minimum requirements of the Asthma 3+ Visit Plan. (See para A.29 of explanatory notes to this Category)</p> <p>Fee: \$61.00 Benefit: 75% = \$45.75 85% = \$51.85</p>
2673	<p style="text-align: center;">OUT-OF-SURGERY CONSULTATIONS</p> <p>(Professional attendance at a place other than the consulting rooms)</p> <p>STANDARD CONSULTATION of more than 5 minutes duration but not more than 25 minutes duration</p> <p>AND which completes the minimum requirements of the Asthma 3+ Visit Plan. (See para A.29 of explanatory notes to this Category)</p> <p>Derived Fee: An amount equal to \$16.00, plus \$17.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - an amount equal to \$16.00 plus \$0.70 per patient.</p>

MEDICAL PRACTITIONER	MEDICAL PRACTITIONER
GROUP A20 - FOCUSSED PSYCHOLOGICAL STRATEGIES	
	<p data-bbox="197 181 1453 259">MEDICAL PRACTITIONER ATTENDANCE (INCLUDING A GENERAL PRACTITIONER, BUT NOT INCLUDING A SPECIALIST OR CONSULTANT PHYSICIAN) ASSOCIATED WITH PROVISION OF FOCUSSED PSYCHOLOGICAL STRATEGIES</p> <p data-bbox="197 293 1453 371">Note: These services may only be provided by a medical practitioner who is registered with the HIC as meeting the requirements to participate in the Better Outcomes in Mental Health Care Initiative. The medical practitioner must provide the service in a general practice participating in the PIP or which is accredited.</p> <p data-bbox="197 405 1453 618">Focussed psychological strategies are specific mental health care management strategies, derived from evidence based psychological therapies, that have been shown to integrate the best external evidence of clinical effectiveness with general practice clinical expertise. These strategies are required to be provided to patients by a credentialed medical practitioner and are time limited; being deliverable, in general, in up to 6 planned sessions. In some instances, following review by the practitioner managing the 3 Step Mental Health Process, up to a further 6 sessions may be approved in any 12 month period to an individual patient. Medical practitioners must be notified to the HIC by the General Practice Mental Health Standards Collaboration that they have met the required standards for higher level mental health skills. A session should last for a minimum of 30 minutes.</p> <p data-bbox="715 674 935 696" style="text-align: center;">FPS ATTENDANCE</p> <p data-bbox="197 707 1453 786">Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders by a medical practitioner registered with the Health Insurance Commission as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes to less than 40 minutes.</p> <p data-bbox="197 842 512 864">SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.31 of explanatory notes to this Category)</i></p> <p data-bbox="92 920 1007 943">2721 Fee: \$70.50 Benefit: 75% = \$52.90 85% = \$59.90</p>
2723	<p data-bbox="197 976 616 999">OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) <i>(See para A.31 of explanatory notes to this Category)</i></p> <p data-bbox="197 1055 1414 1111">Derived Fee: The fee for item 2721, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2721 plus \$1.45 per patient.</p>
2725	<p data-bbox="647 1144 999 1167" style="text-align: center;">FPS EXTENDED ATTENDANCE</p> <p data-bbox="197 1178 1453 1256">Professional attendance for the purpose of providing focussed psychological strategies (from the list included in the Explanatory Notes) for assessed mental health disorders, by a medical practitioner registered with the Health Insurance Commission as meeting the credentialing requirements for provision of this service, and lasting at least 40 minutes.</p> <p data-bbox="197 1312 512 1335">SURGERY CONSULTATION (Professional attendance at consulting rooms) <i>(See para A.31 of explanatory notes to this Category)</i></p> <p data-bbox="92 1391 1007 1413">2725 Fee: \$100.95 Benefit: 75% = \$75.75 85% = \$85.85</p>
2727	<p data-bbox="197 1447 616 1469">OUT-OF-SURGERY CONSULTATION (Professional attendance at a place other than consulting rooms) <i>(See para A.31 of explanatory notes to this Category)</i></p> <p data-bbox="197 1525 1422 1581">Derived Fee: The fee for item 2725, plus \$20.60 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2725 plus \$1.45 per patient.</p>

GROUP A9 - CONTACT LENSES - ATTENDANCES	
CONTACT LENSES FOR SPECIFIED CLASSES OF PATIENTS	
<i>Note: Benefits may not be claimed under Item 10809 where the patient wants the contact lenses for appearance, sporting, work or psychological reasons</i>	
ATTENDANCE FOR THE INVESTIGATION and EVALUATION of a patient for the fitting of CONTACT LENSES, with keratometry and testing with trial lenses and the issue of a prescription - 1 SERVICE IN ANY PERIOD OF 36 CONSECUTIVE MONTHS	
10801	- patients with myopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10802	- patients with manifest hyperopia of 5.0 dioptres or greater (spherical equivalent) in 1 eye (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10803	- patients with astigmatism of 3.0 dioptres or greater in 1 eye (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10804	- patients with irregular astigmatism in either eye, being a condition the existence of which has been confirmed by keratometric observation, if the maximum visual acuity obtainable with spectacle correction is worse than 0.3logMAR (6/12) and if that corrected acuity would be improved by an additional 0.1 logMAR by the use of a contact lens (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10805	- patients with anisometropia of 3.0 dioptres or greater (difference between spherical equivalents) (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10806	- patients with corrected visual acuity of 0.7 logMAR (6/30) or worse in both eyes, being patients for whom a contact lens is prescribed as part of a telescopic system (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10807	- patients for whom a wholly or segmentally opaque contact lens is prescribed for the alleviation of dazzle, distortion or diplopia caused by: (i) pathological mydriasis; or (ii) aniridia; or (iii) coloboma of the iris; or (iv) pupillary malformation or distortion; or (v) significant ocular deformity or corneal opacity whether congenital, traumatic or surgical in origin (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10808	- patients who, by reason of physical deformity, are unable to wear spectacles (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10809	- patients who have a medical or optical condition (other than myopia, hyperopia, astigmatism, anisometropia or a condition to which item 10806 , 10807 or 10808 applies) requiring the use of a contact lens for correction, where the condition is specified on the patient's account (See para A.18 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90
10816	ATTENDANCE FOR THE REFITTING OF CONTACT LENSES with keratometry and testing with trial lenses and the issue of a prescription, where the patient requires a change in contact lens material or basic lens parameters, other than simple power change, because of a structural or functional change in the eye or an allergic response within 36 months of the fitting of a contact lens to which Items 10801 to 10809 apply (See para A.19 of explanatory notes to this Category) Fee: \$98.70 Benefit: 75% = \$74.05 85% = \$83.90



A.32 Telepsychiatry

A.32.1 Telepsychiatry is defined as electronic transmission of psychiatric consultations, advice or services in digital form from one location to another using a data communication link provided by a third party carrier, or carriers. It requires the providers to comply with the International Telecommunications Union Standards which cover all types of videoconferencing from massive bandwidth to internet use. If X-rays are required for a psychiatric consultation then the consultant psychiatrist must comply with the DICOM Standards.

A.32.2 Education and Training

Consultant Psychiatrists must have completed the *online Telepsychiatry Certification Module* available on the Royal Australian and New Zealand College of Psychiatrists (RANZCP) website. The RANZCP will keep a register of those consultant psychiatrists who have completed the *online Telepsychiatry Certification Module* and make it available to the Health Insurance Commission (HIC) for auditing purposes.

A.32.3 Duration of Telepsychiatry Consultation

For items 353 to 358 the **time** provides a range of options equal to those provided in items 300 to 308 to allow for the appropriate treatment depending on the requirements of the treatment plan.

A.32.4 Number of Consultations in a Calendar Year

Items 353 to 358 may only be claimed for up to a maximum of 12 consultations in aggregate for each patient in a calendar year. After every fourth telepsychiatry session the consultant psychiatrist must see the patient face-to-face. Items 364 to 370 may be claimed for up to a maximum of three face-to-face consultations for each patient per calendar year. Items 364 to 370 must be used to ensure that Medicare payments continue for further telepsychiatry consultations.

If the number of attendances in aggregate to which items 300 to 308 and items 353 to 370 apply exceeds 50 for a single patient in any calendar year, any further attendances on that patient in that calendar year would be covered by items 310 to 318.

A.32.5 Documenting the Telepsychiatry Session

For items 353 to 370 the psychiatrist must keep a record of the treatment provided during an episode of care via telepsychiatry sessions or face-to-face consultations and must convey this in writing to the referring medical practitioner after the first session and then, at a minimum, after every six consultations.

A.32.6 Geographical

Telepsychiatry items 353 to 358 are available for use when a consultant psychiatrist is located in the following Statistical Local Areas (SLAs):

- M1 (Capital City Urban Centre)
- M2 (Other Metropolitan Urban Centre population 100,000+)
- R1 (Large Rural Centre population 25,000 to 99,000)
- And a referred patient is located in:
 - R1 (Large Rural Centre population 25,000 to 99,000)
 - R2 (Small Rural Centre population 10,000 to 24,999)
 - R3 (Other Rural Area population <10,000)
 - Rem1 (Remote Centre population 5,000+)
 - Rem2 (Other remote area population <5,000+)

The consultant psychiatrist **cannot be located in the same SLA as the patient**. For example:

1. *A consultant psychiatrist conducts telepsychiatry consultations with a patient from his/her consulting rooms in Sydney CBD to the patient who is located in Albury, NSW. The consultant also visits Albury once a month as part of a "fly-in, fly-out" psychiatry service. When the consultant is in Albury and a consultation is required, he/she must conduct a face-to-face session with the patient. If 4 telepsychiatry sessions have already been conducted the consultant psychiatrist would claim an item in the ranges 364 to 370. If less than 4 telepsychiatry sessions have been conducted then the psychiatrist would use the current items 300 to 308.*
2. *If a consultant psychiatrist is located in Ballarat and the patient is also in Ballarat, the consultant would not be permitted to claim Medicare items for a consultation via telepsychiatry.*

A.32.7 Formal Review

A formal review mechanism will be developed to monitor the effectiveness of the Telepsychiatry items.

CONSULTANT PSYCHIATRIST		CONSULTANT PSYCHIATRIST	
GROUP A8 - CONSULTANT PSYCHIATRIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES			
CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION VIA TELEPSYCHIATRY FOR ASSESSMENT, DIAGNOSIS AND TREATMENT			
<p>A telepsychiatry consultation by a consultant physician in the practice of his or her specialty of PSYCHIATRY (not being an attendance to which items 300 to 319 apply), where:</p> <ul style="list-style-type: none"> -the patient is referred to him or her by a medical practitioner for assessment, diagnosis and/or treatment, -that consultation and any other consultation to which items 353 to 358 apply, have not exceeded 12 consultations in a calendar year, -a minimum of one face-to-face consultation (items 364 to 370) is conducted with the patient after every fourth telepsychiatry consultation, and -any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. 			
† 353	A telepsychiatry consultation of not more than 15 minutes duration. <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$40.40	Benefit: 75% = \$30.30 85% = \$34.35
† 355	A telepsychiatry consultation of more than 15 minutes duration but not more than 30 minutes duration. <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$80.65	Benefit: 75% = \$60.50 85% = \$68.60
† 356	A telepsychiatry consultation of more than 30 minutes duration but not more than 45 minutes duration. <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$118.25	Benefit: 75% = \$88.70 85% = \$100.55
† 357	A telepsychiatry consultation of more than 45 minutes duration but not more than 75 minutes duration <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$163.20	Benefit: 75% = \$122.40 85% = \$138.75
† 358	A telepsychiatry consultation of more than 75 minutes duration <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$198.80	Benefit: 75% = \$149.10 85% = \$169.00
CONSULTANT PSYCHIATRIST, REFERRED CONSULTATION FOR ASSESSMENT, DIAGNOSIS AND TREATMENT FOLLOWING TELEPSYCHIATRY			
<p>Professional attendance by a consultant physician in the practice of his or her specialty of PSYCHIATRY, where:</p> <ul style="list-style-type: none"> -the patient is referred to him or her by a medical practitioner, -that attendance occurs following four telepsychiatry consultations (items 353 to 358), - where that attendance and any other attendance to which items 364 to 370 apply does not exceed three consultations per patient in a calendar year. -any other attendance to which items 300 to 308 and 353 to 370 apply, have not exceeded the sum of 50 attendances in a calendar year. <p>These items may only be used after every fourth telepsychiatry consultation conducted in accordance with items 353 to 358.</p>			
† 364	A face-to-face attendance of not more than 15 minutes duration. <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$35.10	Benefit: 75% = \$26.35 85% = \$29.85
† 366	A face-to-face attendance of more than 15 minutes duration but not more than 30 minutes duration <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$70.15	Benefit: 75% = \$52.65 85% = \$59.65
† 367	A face-to-face attendance of more than 30 minutes duration but not more than 45 minutes duration. <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$102.80	Benefit: 75% = \$77.10 85% = \$87.40
† 369	A face-to-face attendance of more than 45 minutes duration but not more than 75 minutes duration <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$141.90	Benefit: 75% = \$106.45 85% = \$120.65
† 370	A face-to-face attendance of more than 75 minutes duration. <i>(See para A.32 of explanatory notes to this Category)</i>	Fee: \$172.85	Benefit: 75% = \$129.65 85% = \$146.95

DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

CATEGORY 2



CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

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CATEGORY 2 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

EXPLANATORY NOTES

MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

D1.1 Neuromuscular Diagnosis (Item [11012](#))

D1.1.1 Based on advice from the Australian Association of Neurologists, Medicare benefits are not payable under Item [11012](#) for quantitative sensory nerve testing using “Neurometer CPT” diagnostic devices. The advice indicated that the device was still in the evaluation and research stage and did not have widespread clinical application.

D1.2 Investigation of Central Nervous System Evoked Responses (Items [11024](#) and [11027](#))

D1.2.1 In the context of these items a study refers to one or more averaged samples of electrical activity recorded from one or more sites in the central nervous system in response to the same stimulus.

D1.2.2 Second or subsequent studies refer to either stimulating the point of stimulation (e.g. right eye or left median nerve) with a different stimulus or stimulating another point of stimulation (e.g. left eye or right median nerve).

D1.2.3 Items [11024](#) and [11027](#) are not intended to cover bio-feedback techniques.

D1.3 Electroretinography (Items [11204](#), [11205](#), [11210](#), [11211](#))

D1.3.1 Current professional guidelines and standards for electroretinography, electroculography and pattern retinography are produced by the International Society for Clinical Electrophysiology of Vision (ISCEV).

D1.4 Computerised Perimetry (Items [11222](#) and [11225](#))

D1.4.1 These items relate to computerised perimetry (bilateral or unilateral) where a third or subsequent examination becomes necessary in a 12 month period. As indicated in the descriptions, these items apply only where a further examination is indicated in the presence of one of the following conditions:-

established glaucoma where surgery is being considered or has been performed, and where there has been definite progression of damage over a 12 month period;
established neurologic disease which may be progressive; or
for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease.

D1.4.2 Claims for benefits in respect of Items [11222](#) and [11225](#) should be accompanied by clinical details confirming the presence of one of the above conditions. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.7 of the General Explanatory Notes.)

D1.5 Orbital Contents (Items [11240](#), [11241](#), [11242](#), [11243](#))

D1.5.1 Where an additional service is necessary items [11242](#) and [11243](#) should be utilised.

D1.6 Electrocochleography (Item [11304](#))

D1.6.1 This item refers to electrocochleography with insertion of electrodes through the tympanic membrane.

D1.7 Non-determinate Audiometry (Item [11306](#))

D1.7.1 This refers to screening audiometry covering those services, one or more, referred to in Items [11309-11321](#) when not performed under the conditions set out in paragraph D1.8.1.

D1.8 Audiology Services (Items [11309](#) - [11321](#))

D1.8.1 A medical service specified in Items [11309](#) to [11321](#) shall be taken to be a medical service for the purposes of payment of benefits if, and only if, it is rendered:

- (a) in conditions that allow the establishment of determinate thresholds;
- (b) in a sound attenuated environment with background noise conditions that comply with Australian Standard AS 1269.3.1998 of the Standards Association of Australia, being that Standard as in force or existing on 1 August 1987; and
- (c) using calibrated equipment that complies with Australian Standard AS 2586-1983 of the Standards Association of Australia, being that Standard as in force or existing on 1 August 1987.

D1.9 Oto-acoustic Emission Audiometry (Item [11332](#))

D1.9.1 Medicare benefits are not payable under Item [11332](#) for routine screening of infants. The equipment used to provide this service must be capable of displaying the recorded emission and not just a pass/fail indicator.

D1.10 Respiratory Function Tests (Item [11503](#))

D1.10.1 The investigations listed hereunder would attract benefits under Item [11503](#). This list has been prepared in consultation with the Thoracic Society of Australia and New Zealand.

- (a) Carbon monoxide diffusing capacity by any method
- (b) Absolute lung volumes by any method
- (c) Assessment of arterial carbon dioxide tension or cardiac output - re breathing method
- (d) Assessment of pulmonary distensibility involving measurement of lung volumes and oesophageal pressure
- (e) Measurement of airway or pulmonary resistance by any method
- (f) Measurement of respiratory muscle strength involving the measurement of trans-diaphragmatic or oesophageal pressures
- (g) Assessment of phrenic nerve function involving percutaneous stimulation and measurement of the compound action potential of the diaphragm
- (h) Measurement of the resistance of the anterior nares or pharynx
- (i) Inhalation provocation testing, including pre-provocation spirometry, the construction of a dose response curve, using histamine, cholinergic agents or non-istonic fluids and post-bronchodilator spirometry
- (j) Exercise testing using incremental workloads with monitoring of ventilatory and cardiac responses at rest, during exercise and recovery on premises equipped with a mechanical ventilator and defibrillator
- (k) Tests of distribution of ventilation involving inhalation of inert gases
- (l) Measurement of gas exchange involving simultaneous collection of arterial blood and expired air with measurements of the partial pressures of oxygen and carbon dioxide in gas and blood
- (m) Multiple inert gas elimination techniques for measuring ventilation perfusion ratios in the lung
- (n) Continuous monitoring of pulmonary function other than spirometry, tidal breathing and minute ventilation, of at least 6 hours duration
- (o) Ventilatory and/or occlusion pressure responses to progressive hypercapnia and progressive hypoxia
- (p) Monitoring pulmonary arterial pressure at rest or during exercise
- (q) Measurement of the strength of inspiratory and expiratory muscles at multiple lung volumes
- (r) Measurement of the respiratory muscle endurance/fatigability by any technique
- (s) Measurement of respiratory muscle strength before and after intravenous injection of placebo and anticholinesterase drugs
- (t) Simulated altitude test involving exposure to hypoxic gas mixtures and measurement of ventilation, heart rate and oxygen saturation at rest and/or during exercise and observation of the effect of supplemental oxygen
- (u) Inhalation provocation testing to specific sensitising agents
- (v) Spirometry performed before and after simple exercise testing undertaken as a provocation test for the investigation of asthma, in premises capable of performing complex lung function tests and equipped with a mechanical ventilator and defibrillator.

D1.11 Investigations of Vascular Disease (Items [11603-11624](#))

D1.11.1 These items relate to examinations performed in the investigation of vascular disease. The fees include components for interpretation of the results and provision of the report which must be performed by a medical practitioner.

D1.12 Twelve-lead Electrocardiography (Item [11700](#))

D1.12.1 Benefits are precluded under this item unless a full 12-lead ECG is performed. Examinations involving less than twelve leads are regarded as part of the accompanying consultation. A 12-lead ECG refers to the recordings produced of 12 views of the heart by various combinations of placement of electrodes.

D1.13 Twelve-lead Electrocardiography, Report Only (Item [11701](#))

D1.13.1 This item provides a benefit where tracings are referred to a medical practitioner for a report without an attendance on the patient by that practitioner. Where a patient is referred to a consultant for a consultation and takes ECG tracings with him/her, a separate benefit is not payable for the consultant's interpretation of the tracings.

D1.14 Electrocardiographic (ECG) Recording of Ambulatory Patient (Items [11708](#), [11709](#))

D1.14.1 Medicare benefits are not payable for ambulatory blood pressure monitoring (under Item [11708](#) or [11709](#) or any other item). Likewise, where blood pressure monitoring and continuous ECG recording are undertaken conjointly on an ambulatory patient for 12 hours or more, benefits are not payable for the blood pressure monitoring or for the continuous ECG recording under Item [11708](#) or [11709](#).

D1.14.2 Items [11708](#) and [11709](#) require the continuous ECG recording of an ambulatory patient for twelve hours or more. Benefits are only payable under these items if the ECG data is analysed and reported on by a specialist physician or consultant physician.

D1.14.3 The changing of a tape or batteries is regarded as a continuation of the service and does not constitute a separate service for benefit purposes. Where a recording is analysed and reported on and a decision is made to undertake a further period of monitoring, the second episode would be regarded as a separate service.

D1.15 Signal Averaged ECG Recording (Item [11713](#))

D1.15.1 Benefits are only payable under this item if the ECG data is analysed and reported on by a specialist physician or a consultant physician.

D1.16 Epicutaneous Patch Testing (Items [12012](#), [12015](#) & [12018](#))

D1.16.1 A standard epicutaneous patch test battery refers to the European Standard Series or the International Contact Research Group Standard Series.

D1.17 Investigations for Sleep Apnoea (Items [12203](#), [12207](#), [12210](#), [12213](#), [12215](#) and [12217](#))

D1.17.1 A “qualified adult sleep medicine practitioner” as described in Items [12203](#) and [12207](#), a “qualified paediatric sleep medicine practitioner” as described in Items [12210](#) and [12213](#) and a “qualified sleep medicine practitioner” as described in Items [12215](#) and [12217](#) means:

For practitioners who commence providing sleep studies before 1 March 1999:

- (a) a person who, before 1 March 1999, has been assessed by the Credentialling Subcommittee (the Credentialling Subcommittee) of the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians as having sufficient training and experience in either adult or paediatric sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies; or
- (b) a person who, before 1 March 1999, has been assessed by the Credentialling Subcommittee as having substantial training or experience in either adult or paediatric sleep medicine but as requiring further specified training or experience in sleep medicine to be competent in independent clinical assessment and management of patients with respiratory sleep disorders and in reporting sleep studies. This will apply for two years after the assessment; or
- (c) a person mentioned in paragraph (b) who has finished the training or gained the experience specified for that person that has been verified by the Credentialling Subcommittee; OR

For practitioners who commence providing sleep studies after 1 March 1999

- (d) a person who after completing at least 12 months core training, including clinical practice in sleep medicine and in reporting sleep studies, has attained Level I or Level II of the Advanced Training program in either Adult or Paediatric Sleep Medicine of the Thoracic Society of Australia and New Zealand and the Australasian Sleep Association; or"
- (e) a person whom the Specialist Advisory Committee in Thoracic and Sleep Medicine of the Royal Australasian College of Physicians has recognised, in writing, as having training equivalent to the training mentioned in paragraph (d) above.

D1.17.2 In relation to paragraph (d) of these items, generally, the patient should be seen in consultation by a qualified sleep medicine practitioner to determine the necessity for the investigation unless the necessity has been clearly established by other means.

D1.17.3 Item [12207](#) relates to overnight investigation of sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period where all of the following conditions apply:-

- the patient has severe cardio-respiratory failure; and
- previous studies have demonstrated failure of continuous positive airway pressure or oxygen; and
- the study is for the adjustment and/or testing of the effectiveness of a positive pressure ventilatory support device (other than nasal continuous positive airway pressure)

D1.17.4 Items [12215](#) and [12217](#) relate to overnight investigation for sleep apnoea where a fourth or subsequent investigation becomes necessary in a twelve month period when therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required.

D1.17.5 Claims for benefits in respect of items [12207](#), [12215](#) and [12217](#) should be accompanied by clinical details confirming the presence of the conditions set out in D1.17.3 and D1.17.4. The claim and the additional information should be lodged with Medicare, for referral to the Central Office of the Commission, in a sealed envelope marked “Medical-in- Confidence”. (see note 8.7 of the General Explanatory Notes.)

D1.18 Bone Densitometry (Items [12306](#) to [12321](#))

D1.18.1 Item 12321 is intended to allow for bone mineral density measurement following a significant change in therapy - e.g. a change in the class of drugs - rather than for a change in the dosage regimen.

D1.18.2 An examination under any of these items covers the measurement of 2 or more sites, interpretation and provision of a report. Two or more sites must include the measurement of bone density of the lumbar spine and proximal femur. If technical difficulties preclude measurement at these sites, other sites can be used for the purpose of measurements. The measurement of bone mineral density at both forearms or both heels or in combination is excluded for the purpose of Medicare benefit.

Referrals

D1.18.3 Bone densitometry services are available on the basis of referral by a medical practitioner to a specialist or consultant physician. However, providers of bone densitometry to whom a patient is referred for management may determine that a bone densitometry service is required in line with the provisions of Items [12306](#), [12309](#), [12312](#), [12315](#), [12318](#) and [12321](#).

D1.18.4 For Items [12306](#) and [12309](#) the referral should specify the indication for the test, namely:

- (a) 1 or more fractures occurring after minimal trauma; or
- (b) monitoring of low bone mineral density proven by previous bone densitometry.

D1.18.5 For Item [12312](#) the referral should specify the indication for the test, namely:

- (a) prolonged glucocorticoid therapy;
- (b) conditions associated with excess glucocorticoid secretion;
- (c) male hypogonadism; or
- (d) female hypogonadism lasting more than 6 months before the age of 45.

D1.18.6 For Item [12315](#) the referral should specify the indication for the test, namely:

- (a) primary hyperparathyroidism;
- (b) chronic liver disease;
- (c) chronic renal disease;
- (d) proven malabsorptive disorders;
- (e) rheumatoid arthritis; or
- (f) conditions associated with thyroxine excess.

D1.18.7 For Item [12318](#) the referral should specify the indication for the test, namely:

- (a) prolonged glucocorticoid therapy;
- (b) conditions associated with excess glucocorticoid secretion;
- (c) male hypogonadism;
- (d) female hypogonadism lasting more than 6 months before the age of 45;
- (e) primary hyperparathyroidism;
- (f) chronic liver disease;
- (g) chronic renal disease;
- (h) proven malabsorptive disorders;
- (i) rheumatoid arthritis; or
- (j) conditions associated with thyroxine excess.

Definitions

D1.18.8 Low bone mineral density is present when the bone (organ) mineral density falls more than 1.5 standard deviations below the age matched mean or more than 2.5 standard deviations below the young normal mean at the same site and in the same gender.

D1.18.9 For Items [12312](#) and [12318](#)

- (a) 'Prolonged glucocorticoid therapy' is defined as the commencement of a dosage of inhaled glucocorticoid equivalent to or greater than 800 micrograms beclomethasone dipropionate or budesonide per day; or
- (b) a supraphysiological glucocorticoid dosage equivalent to or greater than 7.5 mg prednisolone in an adult taken orally per day for a period anticipated to last for at least 4 months.

D1.18.10 For Items [12312](#) and [12318](#)

- (a) Male hypogonadism is defined as serum testosterone levels below the age matched normal range.

- (b) Female hypogonadism is defined as serum oestrogen levels below the age matched normal range.

D1.18.11 For Items [12315](#) and [12318](#)

A malabsorptive disorder is defined as one or more of the following:

- (a) malabsorption of fat, defined as faecal fat estimated at greater than 18 gm per 72 hours on a normal fat diet; or
- (b) bowel disease with presumptive vitamin D malabsorption as indicated by a sub-normal circulating 25-hydroxyvitamin D level; or
- (c) histologically proven Coeliac disease.

DIAGNOSTIC	NEUROLOGY
GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
SUBGROUP 1 - NEUROLOGY	
11000	ELECTROENCEPHALOGRAPHY, not being a service: (a) associated with a service to which item 11003 , 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices (Anaes.) Fee: \$99.80 Benefit: 75% = \$74.85 85% = \$84.85
11003	ELECTROENCEPHALOGRAPHY, prolonged recording of at least 3 hours duration, not being a service: (a) associated with a service to which item 11000 , 11006 or 11009 applies; or (b) involving quantitative topographic mapping using neurometrics or similar devices Fee: \$264.10 Benefit: 75% = \$198.10 85% = \$224.50
11006	ELECTROENCEPHALOGRAPHY, temporosphenoidal, not being a service involving quantitative topographic mapping using neurometrics or similar devices Fee: \$135.40 Benefit: 75% = \$101.55 85% = \$115.10
11009	ELECTROCORTICOGRAPHY Fee: \$184.65 Benefit: 75% = \$138.50 85% = \$157.00
11012	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 1 nerve OR ELECTROMYOGRAPHY of 1 or more muscles using concentric needle electrodes OR both these examinations (not being a service associated with a service to which item 11015 or 11018 applies) <i>(See para D1.1 of explanatory notes to this Category)</i> Fee: \$90.75 Benefit: 75% = \$68.10 85% = \$77.15
11015	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 2 or 3 nerves with or without electromyography (not being a service associated with a service to which item 11012 or 11018 applies) Fee: \$121.55 Benefit: 75% = \$91.20 85% = \$103.35
11018	NEUROMUSCULAR ELECTRODIAGNOSIS conduction studies on 4 or more nerves with or without electromyography OR recordings from single fibres of nerves and muscles OR both of these examinations (not being a service associated with a service to which item 11012 or 11015 applies) Fee: \$181.60 Benefit: 75% = \$136.20 85% = \$154.40
11021	NEUROMUSCULAR ELECTRODIAGNOSIS repetitive stimulation for study of neuromuscular conduction OR electromyography with quantitative computerised analysis OR both of these examinations Fee: \$121.55 Benefit: 75% = \$91.20 85% = \$103.35
11024	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials - 1 or 2 studies <i>(See para D1.2 of explanatory notes to this Category)</i> Fee: \$92.35 Benefit: 75% = \$69.30 85% = \$78.50
11027	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials - 3 or more studies <i>(See para D1.2 of explanatory notes to this Category)</i> Fee: \$136.95 Benefit: 75% = \$102.75 85% = \$116.45
SUBGROUP 2 - OPHTHALMOLOGY	
11200	PROVOCATIVE TEST OR TESTS FOR GLAUCOMA, including water drinking Fee: \$33.05 Benefit: 75% = \$24.80 85% = \$28.10
11203	TONOGRAPHY in the investigation or management of glaucoma, 1 or both eyes using an electrical tonography machine producing a directly recorded tracing Fee: \$55.90 Benefit: 75% = \$41.95 85% = \$47.55
11204	ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards <i>(See para D1.3 of explanatory notes to this Category)</i> Fee: \$87.75 Benefit: 75% = \$65.85 85% = \$74.60
11205	ELECTROOCULOGRAPHY of one or both eyes performed according to current professional guidelines or standards <i>(See para D1.3 of explanatory notes to this Category)</i> Fee: \$87.75 Benefit: 75% = \$65.85 85% = \$74.60

DIAGNOSTIC		OPHTHALMOLOGY	
11210	PATTERN ELECTRORETINOGRAPHY of one or both eyes by computerised averaging techniques, including 3 or more studies performed according to current professional guidelines or standards (See para D1.3 of explanatory notes to this Category) Fee: \$87.75	Benefit: 75% = \$65.85	85% = \$74.60
11211	DARK ADAPTOMETRY of one or both eyes with a quantitative (log cd/m2) estimation of threshold in log lumens at 45 minutes of dark adaptations (See para D1.3 of explanatory notes to this Category) Fee: \$87.75	Benefit: 75% = \$65.85	85% = \$74.60
11212	OPTIC FUNDI, examination of, following intravenous dye injection Fee: \$56.90	Benefit: 75% = \$42.70	85% = \$48.40
11215	RETINAL PHOTOGRAPHY, multiple exposures of 1 eye with intravenous dye injection Fee: \$99.70	Benefit: 75% = \$74.80	85% = \$84.75
11218	RETINAL PHOTOGRAPHY, multiple exposures of both eyes with intravenous dye injection Fee: \$123.15	Benefit: 75% = \$92.40	85% = \$104.70
11221	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, <u>bilateral</u> - to a maximum of 2 examinations (including examinations to which item 11224 applies) in any 12 month period Fee: \$54.95	Benefit: 75% = \$41.25	85% = \$46.75
11222	FULL QUANTITATIVE COMPUTERISED PERIMETRY (automated absolute static threshold), performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, <u>bilateral</u> , where it can be demonstrated that a further examination is indicated in the same 12 month period to which Item 11221 applies due to presence of 1 of the following conditions:- <ul style="list-style-type: none"> . established glaucoma (where surgery is being considered) where there has been definite progression of damage over a 12 month period; . established neurologic disease which may be progressive; or . for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease - each additional examination (See para D1.4 and D1.6 of explanatory notes to this Category) Fee: \$54.95	Benefit: 75% = \$41.25	85% = \$46.75
11224	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) performed by or on behalf of a specialist in the practice of his or her specialty, where indicated by the presence of relevant ocular disease or suspected pathology of the visual pathways or brain with assessment and report, <u>unilateral</u> - to a maximum of 2 examinations (including examinations to which item 11221 applies) in any 12 month period Fee: \$33.10	Benefit: 75% = \$24.85	85% = \$28.15
11225	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold), performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, <u>unilateral</u> , where it can be demonstrated that a further examination is indicated in the same 12 month period to which item 11224 applies due to presence of one of the following conditions:- <ul style="list-style-type: none"> . established glaucoma (where surgery is being considered) where there has been definite progression of damage over a 12 month period; . established neurologic disease which may be progressive; or . for the monitoring of systemic drug toxicity, where there is also other disease such as glaucoma or neurologic disease - each additional examination (See para D1.4 and D1.6 of explanatory notes to this Category) Fee: \$33.10	Benefit: 75% = \$24.85	85% = \$28.15
11235	EXAMINATION OF THE EYE BY IMPRESSION CYTOLOGY OF CORNEA for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report Fee: \$99.45	Benefit: 75% = \$74.60	85% = \$84.55
11240	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for one eye, not being a service associated with a service to which items in Group II apply (See para D1.5 of explanatory notes to this Category) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10

11241	<p>ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for both eyes, not being a service associated with a service to which items in Group II apply (See para D1.5 of explanatory notes to this Category)</p> <p>Fee: \$84.05 Benefit: 75% = \$63.05 85% = \$71.45</p>
11242	<p>ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group II apply (See para D1.5 of explanatory notes to this Category)</p> <p>Fee: \$65.00 Benefit: 75% = \$48.75 85% = \$55.25</p>
11243	<p>ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group II apply (See para D1.5 of explanatory notes to this Category)</p> <p>Fee: \$65.00 Benefit: 75% = \$48.75 85% = \$55.25</p>
SUBGROUP 3 - OTOLARYNGOLOGY	
11300	<p>BRAIN stem evoked response audiometry (Anaes.)</p> <p>Fee: \$156.05 Benefit: 75% = \$117.05 85% = \$132.65</p>
11303	<p>ELECTROCOCHLEOGRAPHY, extratympanic method, 1 or both ears</p> <p>Fee: \$156.05 Benefit: 75% = \$117.05 85% = \$132.65</p>
11304	<p>ELECTROCOCHLEOGRAPHY, transtympanic membrane insertion technique, 1 or both ears (See para D1.6 of explanatory notes to this Category)</p> <p>Fee: \$256.95 Benefit: 75% = \$192.75 85% = \$218.45</p>
11306	<p>Nondeterminate AUDIOMETRY (See para D1.7 of explanatory notes to this Category)</p> <p>Fee: \$17.80 Benefit: 75% = \$13.35 85% = \$15.15</p>
11309	<p>AUDIOGRAM, air conduction (See para D1.8 of explanatory notes to this Category)</p> <p>Fee: \$21.30 Benefit: 75% = \$16.00 85% = \$18.15</p>
11312	<p>AUDIOGRAM, air and bone conduction or air conduction and speech discrimination (See para D1.8 of explanatory notes to this Category)</p> <p>Fee: \$30.10 Benefit: 75% = \$22.60 85% = \$25.60</p>
11315	<p>AUDIOGRAM, air and bone conduction and speech (See para D1.8 of explanatory notes to this Category)</p> <p>Fee: \$39.90 Benefit: 75% = \$29.95 85% = \$33.95</p>
11318	<p>AUDIOGRAM, air and bone conduction and speech, with other Cochlear tests (See para D1.8 of explanatory notes to this Category)</p> <p>Fee: \$49.20 Benefit: 75% = \$36.90 85% = \$41.85</p>
11321	<p>GLYCEROL INDUCED COCHLEAR FUNCTION CHANGES assessed by a minimum of 4 air conduction and speech discrimination tests (Klockoff's tests) (See para D1.8 of explanatory notes to this Category)</p> <p>Fee: \$93.55 Benefit: 75% = \$70.20 85% = \$79.55</p>
11324	<p>IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - not being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies</p> <p>Fee: \$26.65 Benefit: 75% = \$20.00 85% = \$22.70</p>
11327	<p>IMPEDANCE AUDIOGRAM involving tympanometry and measurement of static compliance and acoustic reflex performed by, or on behalf of, a specialist in the practice of his or her specialty, where the patient is referred by a medical practitioner - being a service associated with a service to which item 11309, 11312, 11315 or 11318 applies</p> <p>Fee: \$16.00 Benefit: 75% = \$12.00 85% = \$13.60</p>
11330	<p>IMPEDANCE AUDIOGRAM where the patient is not referred by a medical practitioner - 1 examination in any 4 week period</p> <p>Fee: \$6.40 Benefit: 75% = \$4.80 85% = \$5.45</p>

DIAGNOSTIC	RESPIRATORY
11332	<p>OTO-ACOUSTIC EMISSION AUDIOMETRY for the detection of permanent congenital hearing impairment, performed by or on behalf of a specialist or consultant physician, on an infant or child who is at risk due to one or more of the following factors:-</p> <p>(i) admission to a neonatal intensive care unit; or (ii) family history of hearing impairment; or (iii) intra-uterine or perinatal infection (either suspected or confirmed); or (iv) birthweight less than 1.5kg; or (v) craniofacial deformity; or (vi) birth asphyxia; or (vii) chromosomal abnormality, including Down's Syndrome; or (viii) exchange transfusion;</p> <p>and where:-</p> <p>- the patient is referred by another medical practitioner; and - middle ear pathology has been excluded by specialist opinion (See para D1.9 of explanatory notes to this Category)</p> <p>Fee: \$47.45 Benefit: 75% = \$35.60 85% = \$40.35</p>
11333	<p>CALORIC TEST OF LABYRINTH OR LABYRINTHS</p> <p>Fee: \$36.15 Benefit: 75% = \$27.15 85% = \$30.75</p>
11336	<p>SIMULTANEOUS BITHERMAL CALORIC TEST OF LABYRINTHS</p> <p>Fee: \$36.15 Benefit: 75% = \$27.15 85% = \$30.75</p>
11339	<p>ELECTRONYSTAGMOGRAPHY</p> <p>Fee: \$36.15 Benefit: 75% = \$27.15 85% = \$30.75</p>
SUBGROUP 4 - RESPIRATORY	
11500	<p>BRONCHOSPIROMETRY, including gas analysis</p> <p>Fee: \$135.40 Benefit: 75% = \$101.55 85% = \$115.10</p>
11503	<p>MEASUREMENT OF THE MECHANICAL OR GAS EXCHANGE FUNCTION OF THE RESPIRATORY SYSTEM, OR OF RESPIRATORY MUSCLE FUNCTION, OR OF VENTILATORY CONTROL MECHANISMS, using measurements of various parameters including pressures, volumes, flow, gas concentrations in inspired or expired air, alveolar gas or blood, electrical activity of muscles (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed (See para D1.10 of explanatory notes to this Category)</p> <p>Fee: \$112.45 Benefit: 75% = \$84.35 85% = \$95.60</p>
11506	<p>MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing performed before and after inhalation of bronchodilator - each occasion at which 1 or more such tests are performed</p> <p>Fee: \$16.65 Benefit: 75% = \$12.50 85% = \$14.20</p>
11509	<p>MEASUREMENT OF RESPIRATORY FUNCTION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex respiratory function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed</p> <p>Fee: \$28.95 Benefit: 75% = \$21.75 85% = \$24.65</p>
11512	<p>CONTINUOUS MEASUREMENT OF THE RELATIONSHIP BETWEEN FLOW AND VOLUME DURING EXPIRATION OR INSPIRATION involving a permanently recorded tracing and written report, performed before and after inhalation of bronchodilator, with continuous technician attendance in a laboratory equipped to perform complex lung function tests (the tests being performed under the supervision of a specialist or consultant physician or in the respiratory laboratory of a hospital) - each occasion at which 1 or more such tests are performed</p> <p>Fee: \$50.05 Benefit: 75% = \$37.55 85% = \$42.55</p>
SUBGROUP 5 - VASCULAR	
11600	<p>BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - each day of monitoring for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies and where not performed in association with the administration of anaesthesia)</p> <p>Fee: \$56.15 Benefit: 75% = \$42.15 85% = \$47.75</p>

DIAGNOSTIC	CARDIOVASCULAR
11603	<p>EXAMINATION OF PERIPHERAL VESSELS AT REST (unilateral or bilateral) excluding the cavernosal artery and dorsal artery of the penis, with hard copy recordings of wave forms, involving 1 of the following techniques Doppler recordings (pulsed, continuous wave, or both) of blood flow velocity with or without pulse volume recordings; Doppler recordings involving real time fast fourier transform analysis; venous occlusion plethysmography; strain-gauge plethysmography; impedance plethysmography; or photo plethysmography; (not being a service to which item 11612 or 11615 applies) - 1 examination and report (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$41.90 Benefit: 75% = \$31.45 85% = \$35.65</p>
11606	<p>- 2 examinations of the kind referred to in item 11603 and report (not being a service associated with a service to which item 11612 or 11615 applies) (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$59.40 Benefit: 75% = \$44.55 85% = \$50.50</p>
11609	<p>- 3 or more examinations of the kind referred to in item 11603 and report (not being a service to which item 11612 or 11615 applies) (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$77.10 Benefit: 75% = \$57.85 85% = \$65.55</p>
11612	<p>EXAMINATION OF PERIPHERAL VESSELS and report, involving any of the techniques referred to in item 11603, with hard copy recording of wave forms before measured exercise using a treadmill or bicycle ergometer, and measurement of pressure after exercise for 10 minutes or until pressure is normal (unilateral or bilateral) (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$77.10 Benefit: 75% = \$57.85 85% = \$65.55</p>
11615	<p>MEASUREMENT OF DIGITAL TEMPERATURE, 1 or more digits, (unilateral or bilateral) and report, with hard copy recording of temperature before and for 10 minutes or more after cold stress testing (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$61.50 Benefit: 75% = \$46.15 85% = \$52.30</p>
11618	<p>EXAMINATION OF CAROTID OR VERTEBRAL VESSELS, or both (unilateral or bilateral) with hard copy recordings of wave forms, involving 1 of the following techniques Doppler real time fast fourier transform analysis; oculo-plethysmography, phonoangiography or both; or periorbital Doppler examination (not being a service associated with a service to which item 55274, 55288 or 55290 applies) - 1 examination and report (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$54.70 Benefit: 75% = \$41.05 85% = \$46.50</p>
11621	<p>- 2 examinations of the kind referred to in item 11618 and report (not being a service associated with a service to which item 55274, 55288 or 55290 applies) (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$82.35 Benefit: 75% = \$61.80 85% = \$70.00</p>
11624	<p>- 3 or more examinations of the kind referred to in item 11618 and report (not being a service associated with a service to which item 55274, 55288 or 55290 applies) (See para D1.11 of explanatory notes to this Category)</p> <p>Fee: \$109.40 Benefit: 75% = \$82.05 85% = \$93.00</p>
11627	<p>PULMONARY ARTERY pressure monitoring during open heart surgery, in a person under 12 years of age Fee: \$185.35 Benefit: 75% = \$139.05 85% = \$157.55</p>
SUBGROUP 6 - CARDIOVASCULAR	
11700	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing and report (See para D1.12 of explanatory notes to this Category)</p> <p>Fee: \$25.30 Benefit: 75% = \$19.00 85% = \$21.55</p>
11701	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, report only where the tracing has been forwarded to another medical practitioner, not in association with a consultation on the same occasion (See para D1.13 of explanatory notes to this Category)</p> <p>Fee: \$12.65 Benefit: 75% = \$9.50 85% = \$10.80</p>
11702	<p>TWELVE-LEAD ELECTROCARDIOGRAPHY, tracing only Fee: \$12.65 Benefit: 75% = \$9.50 85% = \$10.80</p>
11706	<p>PHONOCARDIOGRAPHY with electrocardiograph lead with indirect arterial or venous pulse tracing, with or without apex cardiogram - interpretation and report Fee: \$58.45 Benefit: 75% = \$43.85 85% = \$49.70</p>

DIAGNOSTIC		GASTROENTEROLOGY & COLORECTAL	
11708	CONTINUOUS ECG RECORDING of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), NOT IN ASSOCIATION WITH AMBULATORY BLOOD PRESSURE MONITORING, involving microprocessor based analysis equipment, interpretation and report of recordings by a specialist physician or consultant physician, not being a service to which item 11709 applies <i>(See para D1.14 of explanatory notes to this Category)</i>	Fee: \$103.70	Benefit: 75% = \$77.80 85% = \$88.15
11709	CONTINUOUS ECG RECORDING (Holter) of ambulatory patient for 12 or more hours (including resting ECG and the recording of parameters), NOT IN ASSOCIATION WITH AMBULATORY BLOOD PRESSURE MONITORING, utilising a system capable of superimposition and full disclosure printout of at least 12 hours of recorded ECG data, microprocessor based scanning analysis, with interpretation and report by a specialist physician or consultant physician <i>(See para D1.14 of explanatory notes to this Category)</i>	Fee: \$135.80	Benefit: 75% = \$101.85 85% = \$115.45
11710	AMBULATORY ECG MONITORING, patient activated, single or multiple event recording, utilising a looping memory recording device which is connected continuously to the patient for 12 hours or more and is capable of recording for at least 20 seconds prior to each activation and for 15 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period	Fee: \$42.05	Benefit: 75% = \$31.55 85% = \$35.75
11711	AMBULATORY ECG MONITORING for 12 hours or more, patient activated, single or multiple event recording, utilising a memory recording device which is capable of recording for at least 30 seconds after each activation, including transmission, analysis, interpretation and report - payable once in any 4 week period	Fee: \$22.90	Benefit: 75% = \$17.20 85% = \$19.50
11712	MULTI CHANNEL ECG MONITORING AND RECORDING during exercise (motorised treadmill or cycle ergometer capable of quantifying external workload in watts) or pharmacological stress, involving the continuous attendance of a medical practitioner for not less than 20 minutes, with resting ECG, and with or without continuous blood pressure monitoring and the recording of other parameters, on premises equipped with mechanical respirator and defibrillator	Fee: \$123.30	Benefit: 75% = \$92.50 85% = \$104.85
11713	SIGNAL AVERAGED ECG RECORDING involving not more than 300 beats, using at least 3 leads with data acquisition at not less than 1000Hz of at least 100 QRS complexes, including analysis, interpretation and report of recording by a specialist physician or consultant physician <i>(See para D1.15 of explanatory notes to this Category)</i>	Fee: \$56.55	Benefit: 75% = \$42.45 85% = \$48.10
11715	BLOOD DYE DILUTION INDICATOR TEST	Fee: \$97.95	Benefit: 75% = \$73.50 85% = \$83.30
11718	IMPLANTED PACEMAKER TESTING involving electrocardiography, measurement of rate, width and amplitude of stimulus, including reprogramming when required, not being a service associated with a service to which item 11700 or 11721 applies	Fee: \$28.15	Benefit: 75% = \$21.15 85% = \$23.95
11721	IMPLANTED PACEMAKER TESTING of atrioventricular (AV) sequential, rate responsive, or antitachycardia pacemakers, including reprogramming when required, not being a service associated with a service to which Item 11700 or 11718 applies	Fee: \$56.55	Benefit: 75% = \$42.45 85% = \$48.10
11724	UP-RIGHT TILT TABLE TESTING for the investigation of syncope of suspected cardiothoracic origin, including blood pressure monitoring, continuous ECG monitoring and the recording of the parameters, and involving an established intravenous line and the continuous attendance of a specialist or consultant physician - on premises equipped with a mechanical respirator and defibrillator	Fee: \$136.95	Benefit: 75% = \$102.75 85% = \$116.45
SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL			
11800	OESOPHAGEAL MOTILITY TEST, manometric	Fee: \$141.50	Benefit: 75% = \$106.15 85% = \$120.30
11810	CLINICAL ASSESSMENT of GASTRO-OESOPHAGEAL REFLUX DISEASE involving 24 hour pH monitoring, including analysis, interpretation and report and including any associated consultation	Fee: \$141.50	Benefit: 75% = \$106.15 85% = \$120.30
11830	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR involving anal manometry or measurement of anorectal sensation or measurement of the rectosphincteric reflex	Fee: \$151.40	Benefit: 75% = \$113.55 85% = \$128.70

DIAGNOSTIC	GENITO/URINARY
11833	DIAGNOSIS of ABNORMALITIES of the PELVIC FLOOR and sphincter muscles involving electromyography or measurement of pudendal and spinal nerve motor latency Fee: \$202.50 Benefit: 75% = \$151.90 85% = \$172.15
SUBGROUP 8 - GENITO/URINARY PHYSIOLOGICAL INVESTIGATIONS	
11900	URINE FLOW STUDY including peak urine flow measurement, not being a service associated with a service to which item 11918 applies Fee: \$22.35 Benefit: 75% = \$16.80 85% = \$19.00
11903	CYSTOMETROGRAPHY, not being a service associated with a service to which item 11912 , 11915 , 11918 , 11012-11027 , 11921 , 36800 or any item in Group I3 applies Fee: \$90.10 Benefit: 75% = \$67.60 85% = \$76.60
11906	URETHRAL PRESSURE PROFILOMETRY, not being a service associated with a service to which item 11909 , 11918 , 11012-11027 , 11921 , 36800 or any item in Group I3 applies Fee: \$90.10 Benefit: 75% = \$67.60 85% = \$76.60
11909	URETHRAL PRESSURE PROFILOMETRY WITH simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11906 , 11915 , 11918 , 36800 or any item in Group I3 applies Fee: \$133.80 Benefit: 75% = \$100.35 85% = \$113.75
11912	CYSTOMETROGRAPHY with simultaneous measurement of rectal pressure, not being a service associated with a service to which item 11903 , 11915 , 11918 , 11012-11027 , 11921 , 36800 or any item in Group I3 applies (Anaes.) Fee: \$133.80 Benefit: 75% = \$100.35 85% = \$113.75
11915	CYSTOMETROGRAPHY with simultaneous measurement of urethral sphincter electromyography, not being a service associated with a service to which item 11903 , 11909 , 11912 , 11918 , 11012-11027 , 11921 , 36800 or any item in Group I3 applies (Anaes.) Fee: \$133.80 Benefit: 75% = \$100.35 85% = \$113.75
11917	CYSTOMETROGRAPHY IN CONJUNCTION WITH ULTRASOUND OF 1 OR MORE COMPONENTS OF THE URINARY TRACT, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all associated imaging by any approach, not being a service associated with a service to which items 11012-11027 , 11900-11915 , 11918 , 11921 and 36800 apply. (Anaes.) Fee: \$347.25 Benefit: 75% = \$260.45 85% = \$295.20
11918	CYSTOMETROGRAPHY IN CONJUNCTION WITH CONTRAST MICTURATING CYSTOURETHROGRAPHY, with measurement of any 1 or more of urine flow rate, urethral pressure profile, rectal pressure, urethral sphincter electromyography; including all associated imaging by any approach, not being a service associated with a service to which items 11012-11027 , 11900-11915 , 11918 , 11921 and 36800 apply (Anaes.) Fee: \$347.25 Benefit: 75% = \$260.45 85% = \$295.20
11921	BLADDER WASHOUT TEST for localisation of urinary infection not including bacterial counts for organisms in specimens Fee: \$60.85 Benefit: 75% = \$45.65 85% = \$51.75
SUBGROUP 9 - ALLERGY TESTING	
12000	SKIN SENSITIVITY TESTING for allergens, USING 1 TO 20 ALLERGENS, not being a service associated with a service to which item 12012 , 12015 , 12018 or 12021 applies Fee: \$31.55 Benefit: 75% = \$23.70 85% = \$26.85
12003	SKIN SENSITIVITY TESTING for allergens, USING MORE THAN 20 ALLERGENS, not being a service associated with a service to which item 12012 , 12015 , 12018 or 12021 applies Fee: \$47.70 Benefit: 75% = \$35.80 85% = \$40.55
12012	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using less than the number of allergens included in a standard patch test battery <i>(See para D1.16 of explanatory notes to this Category)</i> Fee: \$16.85 Benefit: 75% = \$12.65 85% = \$14.35
12015	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery <i>(See para D1.16 of explanatory notes to this Category)</i> Fee: \$50.65 Benefit: 75% = \$38.00 85% = \$43.10

DIAGNOSTIC		OTHER
12018	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis using all of the allergens in a standard patch test battery and additional allergens to a total of up to and including 50 allergens (See para D1.16 of explanatory notes to this Category)	Fee: \$65.20 Benefit: 75% = \$48.90 85% = \$55.45
12021	EPICUTANEOUS PATCH TESTING in the investigation of allergic dermatitis, performed by or on behalf of a specialist in the practice of his or her specialty, using more than 50 allergens	Fee: \$95.55 Benefit: 75% = \$71.70 85% = \$81.25
SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS		
12200	COLLECTION OF SPECIMEN OF SWEAT by iontophoresis	Fee: \$30.15 Benefit: 75% = \$22.65 85% = \$25.65
12203	<p>OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE:</p> <p>(a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed;</p> <p>(b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner;</p> <p>(c) the patient is referred by a medical practitioner;</p> <p>(d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation;</p> <p>(e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report ; and</p> <p>(f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient</p> <p>- payable only in relation to each of the first 3 occasions the investigation is performed in any 12 month period. (See para D1.17 of explanatory notes to this Category)</p>	Fee: \$476.75 Benefit: 75% = \$357.60 85% = \$419.65
12207	<p>OVERNIGHT INVESTIGATION FOR SLEEP APNOEA FOR A PERIOD OF AT LEAST 8 HOURS DURATION, FOR AN ADULT AGED 18 YEARS AND OVER WHERE:</p> <p>(a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recordings of EEG, EOG, submental EMG, anterior tibial EMG, respiratory movement, airflow, oxygen saturation and ECG are performed;</p> <p>(b) a technician is in continuous attendance under the supervision of a qualified sleep medicine practitioner;</p> <p>(c) the patient is referred by a medical practitioner;</p> <p>(d) the necessity for the investigation is determined by a qualified adult sleep medicine practitioner prior to the investigation;</p> <p>(e) polygraphic records are analysed (for assessment of sleep stage, arousals, respiratory events and assessment of clinically significant alterations in heart rate and limb movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; and</p> <p>(f) interpretation and report are provided by a qualified adult sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient</p> <p>where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12203 applies for the adjustment and/or testing of the effectiveness of a <i>positive pressure ventilatory support device</i> (other than nasal continuous positive airway pressure) in sleep, in a <i>patient with severe cardio-respiratory failure</i>, and where previous studies have demonstrated failure of continuous positive airway pressure or oxygen - each additional investigation</p> <p>(See para D1.17 of explanatory notes to this Category)</p>	Fee: \$476.75 Benefit: 75% = \$357.60 85% = \$419.65

DIAGNOSTIC	OTHER
12210	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED 0 - 12 YEARS, WHERE:</p> <ul style="list-style-type: none"> a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. <p>payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. <i>(See para D1.17 of explanatory notes to this Category)</i></p> <p>Fee: \$569.00 Benefit: 75% = \$426.75 85% = \$511.90</p>
12213	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR A CHILD AGED BETWEEN 12 AND 18 YEARS, WHERE:</p> <ul style="list-style-type: none"> a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum), airflow detection, measurement of CO2 either end-tidal or transcutaneous, oxygen saturation and ECG are performed; b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner; c) the patient is referred by a medical practitioner; d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report; f) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient. <p>payable only in relation to the first 3 occasions the investigation is performed in a 12 month period. <i>(See para D1.17 of explanatory notes to this Category)</i></p> <p>Fee: \$512.60 Benefit: 75% = \$384.45 85% = \$455.50</p>

DIAGNOSTIC	OTHER
12215	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED 0 - 12 YEARS, WHERE:</p> <p>a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum) airflow detection, measurement of CO₂ either end-tidal or transcutaneous, oxygen saturation and ECG are performed;</p> <p>b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified paediatric sleep medicine practitioner;</p> <p>(c) the patient is referred by a medical practitioner;</p> <p>(d) the necessity for the investigation is determined by a qualified paediatric sleep medicine practitioner prior to the investigation;</p> <p>(e) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report;</p> <p>(f) the interpretation and report to be provided by a qualified paediatric sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.</p> <p>where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12210 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. (See para D1.17 of explanatory notes to this Category)</p> <p>Fee: \$569.00 Benefit: 75% = \$426.75 85% = \$511.90</p>
12217	<p>OVERNIGHT PAEDIATRIC INVESTIGATION FOR A PERIOD OF AT LEAST 8 HOURS DURATION FOR CHILDREN AGED BETWEEN 12 AND 18 YEARS, WHERE:</p> <p>a) continuous monitoring of oxygen saturation and breathing using a multi-channel polygraph, and recording of EEG (minimum of 4 EEG leads with facility to increase to 6 in selected investigations), EOG, EMG submental +/- diaphragm, respiratory movement must include rib and abdomen (+/- sum), airflow detection, measurement of CO₂ either end-tidal or transcutaneous, oxygen saturation and ECG are performed;</p> <p>b) a technician or registered nurse with sleep technology training is in continuous attendance under the supervision of a qualified sleep medicine practitioner;</p> <p>(c) the patient is referred by a medical practitioner;</p> <p>(d) the necessity for the investigation is determined by a qualified sleep medicine practitioner prior to the investigation; a) polygraphic records are analysed (for assessment of sleep stage, and maturation of sleep indices, arousals, respiratory events and the assessment of clinically significant alterations in heart rate and body movement) with manual scoring, or manual correction of computerised scoring in epochs of not more than 1 minute, and stored for interpretation and preparation of report;</p> <p>b) the interpretation and report to be provided by a qualified sleep medicine practitioner based on reviewing the direct original recording of polygraphic data from the patient.</p> <p>where it can be demonstrated that a further investigation is indicated in the same 12 month period to which item 12213 applies, for therapy with Continuous Positive Airway Pressure (CPAP), bilevel pressure support and/or ventilation is instigated or in the presence of recurring hypoxia and supplemental oxygen is required - each additional investigation. (See para D1.17 of explanatory notes to this Category)</p> <p>Fee: \$512.60 Benefit: 75% = \$384.45 85% = \$455.50</p>
+ 12306	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for:</p> <ul style="list-style-type: none"> . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. <p>Measurement of 2 or more sites - 1 service only in a period of 24 months - including interpretation and report; not being a service associated with a service to which item 12309, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) (See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$83.00 Benefit: 75% = \$62.25 85% = \$70.55</p>
+ 12309	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for:</p> <ul style="list-style-type: none"> . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma; or . for the monitoring of low bone mineral density proven by bone densitometry at least 12 months previously. <p>Measurement of 2 or more sites - 1 service only in a period of 24 months - including interpretation and report; not being a service associated with a service to which item 12306, 12312, 12315, 12318 or 12321 applies (Ministerial Determination) (See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$83.00 Benefit: 75% = \$62.25 85% = \$70.55</p>

DIAGNOSTIC	OTHER
+ 12312	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; or . female hypogonadism lasting more than 6 months before the age of 45. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12315, 12318 or 12321 applies (Ministerial Determination)</p> <p>(See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$83.00 Benefit: 75% = \$62.25 85% = \$70.55</p>
+ 12315	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12318 or 12321 applies (Ministerial Determination)</p> <p>(See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$83.00 Benefit: 75% = \$62.25 85% = \$70.55</p>
+ 12318	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using quantitative computerised tomography, for the diagnosis and monitoring of bone loss associated with 1 or more of the following conditions:</p> <ul style="list-style-type: none"> . prolonged glucocorticoid therapy; . conditions associated with excess glucocorticoid secretion; . male hypogonadism; . female hypogonadism lasting more than 6 months before the age of 45; . primary hyperparathyroidism; . chronic liver disease; . chronic renal disease; . proven malabsorptive disorders; . rheumatoid arthritis; or . conditions associated with thyroxine excess. <p>Where the bone density measurement will contribute to the management of a patient with any of the above conditions - measurement of 2 or more sites - 1 service only in a period of 24 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12321 applies (Ministerial Determination)</p> <p>(See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$83.00 Benefit: 75% = \$62.25 85% = \$70.55</p>
+ 12321	<p>Bone densitometry (performed by a specialist or consultant physician where the patient is referred by another medical practitioner), using dual energy X-ray absorptiometry, for the measurement of bone density 12 months following a significant change in therapy for:</p> <ul style="list-style-type: none"> . established low bone mineral density; or . the confirmation of a presumptive diagnosis of low bone mineral density made on the basis of 1 or more fractures occurring after minimal trauma. <p>Measurement of 2 or more sites - 1 service only in a period of 12 consecutive months - including interpretation and report; not being a service associated with a service to which item 12306, 12309, 12312, 12315 or 12318 applies (Ministerial Determination).</p> <p>(See para D1.18 of explanatory notes to this Category)</p> <p>Fee: \$83.00 Benefit: 75% = \$62.25 85% = \$70.55</p>

NUCLEAR MEDICINE		NUCLEAR MEDICINE	
GROUP D2 - NUCLEAR MEDICINE (NON-IMAGING)			
12500	BLOOD VOLUME ESTIMATION Fee: \$175.60	Benefit: 75% = \$131.70	85% = \$149.30
12503	ERYTHROCYTE RADIOACTIVE UPTAKE SURVIVAL TIME TEST OR IRON KINETIC TEST Fee: \$344.45	Benefit: 75% = \$258.35	85% = \$292.80
12506	GASTROINTESTINAL BLOOD LOSS ESTIMATION involving examination of stool specimens Fee: \$245.90	Benefit: 75% = \$184.45	85% = \$209.05
12509	GASTROINTESTINAL PROTEIN LOSS Fee: \$175.60	Benefit: 75% = \$131.70	85% = \$149.30
12512	RADIOACTIVE B12 ABSORPTION TEST 1 isotope Fee: \$85.10	Benefit: 75% = \$63.85	85% = \$72.35
12515	RADIOACTIVE B12 ABSORPTION TEST 2 isotopes Fee: \$186.40	Benefit: 75% = \$139.80	85% = \$158.45
12518	THYROID UPTAKE (using probe) Fee: \$85.10	Benefit: 75% = \$63.85	85% = \$72.35
12521	PERCHLORATE DISCHARGE STUDY Fee: \$102.70	Benefit: 75% = \$77.05	85% = \$87.30
12524	RENAL FUNCTION TEST (without imaging procedure) Fee: \$128.35	Benefit: 75% = \$96.30	85% = \$109.10
12527	RENAL FUNCTION TEST (with imaging and at least 2 blood samples) Fee: \$68.85	Benefit: 75% = \$51.65	85% = \$58.55
12530	WHOLE BODY COUNT not being a service associated with a service to which another item applies Fee: \$102.70	Benefit: 75% = \$77.05	85% = \$87.30
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 <i>Helicobacter pylori</i> 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 <i>Helicobacter pylori</i> 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	Benefit: 75% = \$51.45	85% = \$58.30



THERAPEUTIC PROCEDURES

CATEGORY 3



CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

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CATEGORY 3 - THERAPEUTIC PROCEDURES

EXPLANATORY NOTES

MISCELLANEOUS THERAPEUTIC PROCEDURES (Group T1)

T1.1 Hyperbaric Oxygen Therapy (Items [13020](#), [13025](#), [13030](#))

T1.1.1 Hyperbaric Oxygen Therapy not covered by these items would attract benefits on an attendance basis.

T1.1.2 For the purposes of these items, a comprehensive hyperbaric medicine facility means a separate hospital area that, on a 24 hour basis:

- (a) is equipped and staffed so that it is capable of providing to a patient: -
 - (180 kilo pascal gauge pressure); and
 - mechanical ventilation and invasive cardiovascular monitoring within a monoplace or multiplace chamber for the duration of the hyperbaric treatment.
- (b) is supported by: -
 - at least one specialist with training in Diving and Hyperbaric Medicine, or medical practitioner who holds the Diploma of Diving and Hyperbaric Medicine of the South Pacific Underwater Medicine Society who is rostered and immediately available to the facility during normal working hours;
- (c) and is staffed by: -
 - a registered medical practitioner with training in Diving and Hyperbaric Medicine who is present in the hyperbaric facility and immediately available at all times when patients are undergoing treatment; and
 - a registered nurse with specific training in hyperbaric patient care to the published standards of the Hyperbaric Oxygen Facility Industry Guidelines (Draft Australian Standard SF346) who is present during hyperbaric oxygen therapy.
- (d) has defined admission and discharge policies.

T1.2 Haemodialysis (Items [13100](#), [13103](#))

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

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

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

T1.3.1 Medicare benefits are not payable in respect of ANY other item in the Medicare Benefits Schedule (including Pathology) in lieu of or in conjunction with Items [13200](#) - [13221](#). Specifically, Medicare benefits are not payable for Items [13200](#) - [13221](#) in association with Item [104](#), [105](#), [14203](#), [14206](#), [35637](#), [66695](#) - [66713](#) or [73521](#) - [73529](#). Items [14203](#) and [14206](#) are not payable for artificial insemination.

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

T1.3.3 The date of service in respect of treatment covered by Items [13200](#), [13203](#), [13206](#), [13209](#) and [13218](#) is DEEMED to be the FIRST DAY of the treatment cycle, except in the case of Item [13218](#) where the service is provided to a patient in hospital. In this case, the account should separately identify the actual date of the service.

T1.3.4 For treatment covered by Items [13200](#), [13203](#), [13206](#) and [13218](#) the account must be provided by the gynaecologist supervising the treatment cycle.

T1.3.5 Embryology laboratory services covered by Items [13200](#) and [13206](#) include egg recovery from aspirated follicular fluid, insemination, monitoring of fertilisation and embryo development, and preparation of gametes or embryos for transfer and freezing. It does not include semen preparation.

T1.3.6 Medicare benefits are not payable for assisted reproductive services rendered in conjunction with surrogacy arrangements where surrogacy is defined as 'an arrangement whereby a woman agrees to become pregnant and to bear a child for another person or persons to whom she will transfer guardianship and custodial rights at or shortly after birth'.

T1.3.7 Items [13200](#), [13206](#), [13215](#) and [13218](#) do not include services provided in relation to artificial insemination using the husband's or donated sperm.

T1.3.8 Items [13200](#) and [13203](#) are linked to the supply of hormones under the Section 100 (National Health Act) arrangements. Providers must notify the Health Insurance Commission of Medicare card numbers of patients using hormones under this program, and hormones are only supplied for patients claiming one of these two items.

T1.4 Administration of Blood or Bone Marrow already Collected (Item [13706](#))

T1.4.1 Item [13706](#) is payable for the transfusion of blood, or platelets or white blood cells or bone marrow or gamma globulins. This item is not payable when gamma globulin is administered intramuscularly.

T1.5 Collection of Blood (Item [13709](#))

T1.5.1 Medicare benefits are payable under Item [13709](#) for collection of blood for autologous transfusions in respect of an impending operation (whether or not the blood is used), or when homologous blood is required in an emergency situation. T1.5.2

Benefits are not payable under Item [13709](#) for collection of blood for long-term storage for possible future autologous transfusion, or for other forms of directed blood donation.

T1.6 Intensive Care Units (ICU)

T1.6.1 'Intensive Care Unit' means a separate hospital area that:

(a) is equipped and staffed so as to be capable of providing to a patient:

- (i) mechanical ventilation for a period of several days; and
- (ii) invasive cardiovascular monitoring; and

(b) is supported by:

- (i) at least one specialist or consultant physician in the specialty of intensive care who is immediately available and exclusively rostered to the ICU during normal working hours; and
- (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
- (iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

T1.6.2 For Neonatal Intensive Care Units an 'Intensive Care Unit' means a separate hospital area that: (a) is equipped and staffed so as to be capable of providing to a patient, being a newly-born child:

- (i) mechanical ventilation for a period of several days; and
- (ii) invasive cardiovascular monitoring; and

(b) is supported by:

- (i) at least one consultant physician in the specialty of paediatric medicine, appointed to manage the unit, and who is immediately available and exclusively rostered to the ICU during normal working hours; and
- (ii) a registered medical practitioner who is present in the hospital and immediately available to the unit at all times; and
- (iii) a registered nurse for at least 18 hours in each day; and

(c) has defined admission and discharge policies.

T1.6.3 In respect to T1.6.1(b)(i) above "immediately available" means that the intensivist must be predominantly present in the ICU during normal working hours. Reasonable absences from the ICU would be acceptable to attend conferences, meetings and other commitments which might involve absences of up to 2 hours during the working day.

T1.6.4 Medicare benefits are payable under the 'management' items only once per day irrespective of the number of intensivists involved with the patient on that day. However, benefits are also payable for an attendance by another specialist/consultant physician who is not managing the patient but who has been asked to attend the patient. Where appropriate, accounts should be endorsed to the effect that the consultation was not part of the patient's intensive care management in order to identify which consultations should attract benefits in addition to the intensive care items.

T1.6.5 In respect of Neonatal Intensive Care Units, as defined above, benefits are payable for admissions of babies who meet the following criteria:-

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

T1.6.6 Cases may arise where babies admitted to a Neonatal Intensive Care Unit under the above criteria who, because they no longer satisfy the criteria are ready for discharge, in accordance with accepted discharge policies, but who are physically retained in the Neonatal Intensive Care Unit for other reasons. For benefit purposes such babies must be deemed as being discharged from the Neonatal Intensive Care Unit and not eligible for benefits under items [13870](#), [13873](#), [13876](#), [13879](#), [13882](#), [13885](#) and [13888](#).

T1.6.7 Likewise, benefits are not payable under items [13870](#), [13873](#), [13876](#), [13879](#), [13882](#), [13885](#) and [13888](#) in respect of babies not meeting the above criteria, but who, for whatever other reasons, are physically located in a Neonatal Intensive Care Unit.

T1.6.8

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

T1.7 Procedures Associated with Intensive care (Items [13818](#), [13842](#), [13857](#))

T1.7.1 Item [13818](#) covers the insertion of a right heart balloon catheter (Swan-Ganz catheter). Benefits are payable under this item only once per day except where a second discrete operation is performed on that day.

T1.7.2 Benefits for monitoring of pressures, up to a maximum of 4 on one day, are payable under Item [11600](#) outside of an ICU and Item [13876](#) within an ICU. Benefits are payable under items [13876](#) and [11600](#) once only for each type of pressure in the one day up to a maximum of 4 pressures.

T1.7.3 If a service covered by Item [13842](#) is provided outside of an ICU, in association with, for example, an

anaesthetic, benefits are payable for Item [13842](#) in addition to Item [13870](#) where the services are performed on the same day. Where this occurs, accounts should be endorsed "performed outside of an Intensive Care Unit" against Item [13842](#).

T1.7.4 Benefits are not payable under Item [13857](#) where ventilation is initiated in the context of an anaesthetic for surgery even if it is likely that following surgery the patient will be ventilated in an ICU. In such cases the appropriate anaesthetic item/s should be itemised.

T1.7.5 Medicare benefits are not payable for sampling by arterial puncture under Item [13839](#) in addition to Item [13870](#) (and [13873](#)) on the same day. Benefits are payable under Item [13842](#) (Intra-arterial cannulisation) in addition to Item [13870](#) (and [13873](#)) when performed on the same day.

T1.8 Management and Procedures in Intensive Care Unit (Items [13870](#), [13873](#), [13876](#))

Items [13870](#) and [13873](#)

T1.8.1 Medicare Benefits Schedule fees for Items [13870](#) and [13873](#) represent global daily fees covering all attendances by the intensivist in the ICU (and attendances provided by support medical personnel) and all electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling performed on the patient on the one day. If a patient is transferred from one ICU to another it would be necessary for an arrangement to be made between the two ICUs regarding the billing of the patient.

T1.8.2 Items [13870](#) and [13873](#) should be itemised on accounts according to each calendar day and not per 24 hour period. For periods when patients are in an ICU for very short periods (say less than 2 hours) with minimal ICU management during that time, a fee should not be raised.

Item [13876](#)

T1.8.3 Item [13876](#) covers the monitoring of pressures in an ICU.

T1.8.4 Benefits are attracted under Item [13876](#) only once for each type of pressure on the one day, (up to a maximum of 4 pressures) irrespective of the number of medical practitioners involved in the monitoring of pressures in an ICU.

T1.8.5 Benefits are payable under Items [11600](#) and [11601](#) where monitoring occurs outside the ICU by practitioners not associated with the ICU, eg, an anaesthetist in an operating theatre. Benefits are attracted under items [11600](#) and [11601](#) only once for each type of pressure on the one day (up to a maximum of 4 pressures) irrespective of the number of practitioners involved in monitoring the pressures.

T1.9 Implanted Pump or Reservoir/Drug Delivery Device (Items [13939](#) and [13942](#))

T1.9.1 The fee for Items [13939](#) and [13942](#) 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 Items [13939](#) and [13942](#).

T1.10 PUVA or UVB Therapy (Items [14050](#), [14053](#))

T1.10.1 A component for any necessary subsequent consultation has been included in the Schedule fee for these items. However, the initial consultation preceding commencement of a course of therapy would attract benefits.

T1.11 Laser Photocoagulation (Items [14106](#) - [14132](#))

T1.11.1 The Australasian College of Dermatologists has advised that the following ranges (applicable to an average 4 year old child and an adult) should be used as a reference to the treatment areas specified in Items [14106](#) - [14132](#):

Entire forehead	50 - 75 cm ²
Cheek	55 - 85 cm ²
Nose	10 - 25 cm ²
Chin	10 - 30 cm ²
Unilateral midline anterior - posterior neck	60 - 220 cm ²
Dorsum of hand	25 - 80 cm ²
Forearm	100 - 250 cm ²
Upper arm	105 - 320 cm ²

T1.11.2 Items [14120](#) to [14132](#) apply where additional treatments are indicated in a 12 month period. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Notes.)

RADIATION ONCOLOGY (Group [T2](#))

T2.1 General

T2.1.1 The level of benefits for radiotherapy depends not only on the number of fields irradiated but also on the frequency of irradiation. In the items related to additional fields, it is to be noted that treatment by rotational therapy is considered to be equivalent to the irradiation of three fields (i.e., irradiation of one field plus two additional fields). For example, each attendance

for orthovoltage rotational therapy at the rate of 3 or more treatments per week would attract benefit under Item [15100](#) plus twice Item [15103](#).

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

T2.2 Planning Services (Items [15500](#) - [15536](#))

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

T2.2.2 Medicare benefits are attracted for an initial referred consultation and computerised planning where both take place at the same attendance. However, benefits are not payable for subsequent consultations rendered in association with therapy or planning services in the same course of treatment. Benefits are also payable, under the appropriate radiology item in Group I3, in respect of verification films (or port films) taken during the course of treatment.

T2.3 Brachytherapy of the Prostate (Item [15338](#))

T2.3.1 Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

T2.3.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

OBSTETRICS (Group [T4](#))

T4.1 Antenatal Care (Item [16500](#))

T4.1.1 In addition to routine antenatal attendances covered by Item [16500](#) the following services, where rendered during the antenatal period, attract benefits:-

- (a) Items [16501](#), [16502](#), [16504](#), [16505](#), [16508](#), [16509](#) (but not normally before the 24th week of pregnancy), [16511](#), [16512](#), [16514](#) and [16600](#) to [16636](#).
- (b) The initial consultation at which pregnancy is diagnosed.
- (c) The first referred consultation by a specialist obstetrician when called in to advise on the pregnancy.
- (d) All other services, excluding those in Category 1 and Group [T4](#) of Category 3 not mentioned above.
- (e) Treatment of an intercurrent condition not directly related to the pregnancy.

T4.1.2 Item [16504](#) relates to the treatment of habitual miscarriage by injection of hormones. A case becomes one of habitual miscarriage following two consecutive spontaneous miscarriages or where progesterone deficiency has been proved by hormonal assay of cells obtained from a smear of the lateral vaginal wall.

T4.1.3 Item [16514](#) relates to antenatal cardiotocography in the management of high risk pregnancy. Benefits for this service are not attracted when performed during the course of the labour and delivery.

T4.2 External Cephalic Version for Breech Presentation (Item [16501](#))

T4.2.1 Contraindications for this item are as follows:

Antepartum Haemorrhage (APH)
multiple pregnancy,
fetal anomaly,
Intrauterine Growth Retardation (IUGR),
Caesarean section scar,
uterine anomalies,
obvious cephalopelvic disproportion,
isoimmunization,
premature rupture of the membranes.

T4.3 Labour and Delivery (Items [16515](#), [16518](#), [16519](#), [16525](#))

T4.3.1 Benefits for management of labour and delivery covered by Items [16515](#), [16518](#), [16519](#) and [16525](#) includes the following (where indicated):-

surgical and/or intravenous infusion induction of labour;
forceps or vacuum extraction;
evacuation of products of conception by manual removal (not being an independent procedure);
episiotomy or repair of tears.

T4.3.2 Item [16519](#) covers delivery by any means including Caesarean section. If, however, a patient is referred, or her care is transferred to another medical practitioner for the specific purpose of delivery by Caesarean section, whether because of an emergency situation or otherwise, then Item [16520](#) would be the appropriate item.

T4.3.3 In some instances the obstetrician may not be able to be present at all stages of confinement. In these circumstances, Medicare benefits are payable under Item [16519](#) provided that the doctor attends the patient as soon as possible during the confinement and assumes full responsibility for the mother and baby.

T4.3.4 Two items in Group [T9](#) provide benefits for assistance by a medical practitioner at a Caesarean section. Item

51306 relates to those instances where the Caesarean section is the only procedure performed, while Item [51309](#) applies when other operative procedures are performed at the same time.

T4.3.5 As a rule, 24 weeks would be the period distinguishing a miscarriage from a premature confinement. However, if a live birth has taken place before 24 weeks and the foetus survives for a reasonable period, benefit would be payable under the appropriate confinement item.

T4.3.6 Where, during labour, a medical practitioner hands the patient over to another medical practitioner, benefits are payable under Item [16518](#) for the referring practitioner's services. The second practitioner's services would attract benefits under Item [16515](#) (i.e., management of vaginal delivery) or Item [16520](#) (Caesarean section). If another medical practitioner is called in for the management of the labour and delivery, benefits for the referring practitioner's services should be assessed under Item [16500](#) for the routine antenatal attendances and on a consultation basis for the postnatal attendances, if performed.

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

T4.4 Caesarean Section (Item [16520](#))

T4.4.1 Benefits under this item are attracted only where the patient has been specifically referred to another medical practitioner for the management of the delivery by Caesarean section and the practitioner carrying out the procedure has not rendered any antenatal care. Caesarean sections performed in any other circumstances attract benefits under Item [16519](#).

T4.5 Complicated Confinement (Item [16522](#))

T4.5.1 Conditions that pose a significant risk of maternal death referred to in Item [16522](#) include: -

- severe pre-eclampsia as defined in the Consensus Statement on the Management of Hypertension in pregnancy, published in the Medical Journal of Australia, Volume 158 on 17 May 1993, and as revised;
- cardiac disease (co-managed with a consultant physician or a specialist physician);
- coagulopathy;
- severe autoimmune disease;
- previous organ transplant; or
- pre-existing renal or hepatic failure.

T4.6 Post-Partum Care (Items [16564-16573](#))

T4.6.1 The Schedule fees and benefits payable for Items [16519](#) and [16520](#) cover all postnatal attendances on the mother and the baby, except in the following circumstances:-

- (i) where the medical services rendered are outside those covered by a consultation, e.g., blood transfusion;
- (ii) where the condition of the mother and/or baby is such as to require the services of another practitioner (e.g., paediatrician, gynaecologist, etc);
- (iii) where the patient is transferred, at arms length, to another medical practitioner for routine post-partum, care (eg mother and/or baby returning from a larger centre to a country town or transferring between hospitals following confinement). In such cases routine postnatal attendances attract benefits on an attendance basis. The transfer of a patient within a group practice would not qualify for benefits under this arrangement except in the case of Items [16515](#) and [16518](#). These items cover those occasions when a patient is handed over while in labour from the practitioner who under normal circumstances would have delivered the baby, but because of compelling circumstances decides to transfer the patient to another practitioner for the delivery;
- (iv) where during the postnatal period a condition occurs which requires treatment outside the scope of normal postnatal care;
- (v) in the management of premature babies (i.e. babies born prior to the end of the 37th week of pregnancy or where the birth weight of the baby is less than 2500 grams) during the period that close supervision is necessary.

T4.6.2 Normal postnatal care by a medical practitioner would include:- (i) uncomplicated care and check of -

- lochia
 - fundus
 - perineum and vulva/episiotomy site
 - temperature
 - bladder/urination
 - bowels
- (ii) advice and support for establishment of breast feeding
 - (iii) psychological assessment and support
 - (iv) rhesus status
 - (v) rubella status and immunisation
 - (vi) contraception advice/management

T4.6.3 Examinations of apparently normal newborn infants by consultant or specialist paediatricians do not attract benefits

T4.6.4 Items [16564](#) to [16573](#) relate to postnatal complications and should not be itemised in respect of a normal delivery. To qualify for benefits under these items, the patient is required to be transferred to theatre, or be administered general anaesthesia or epidural injection for the performance of the procedure. Utilisation of the items will be closely monitored to ensure appropriate usage.

T4.7 Interventional Techniques ([16600-16636](#))

T4.7.1 For Items [16600](#) to [16636](#), [35518](#) and [35674](#) there is no component in the Schedule fee for the associated ultrasound. Benefits are attracted for the ultrasound under the appropriate items in Group [11](#) of the Diagnostic Imaging Services Table. If diagnostic ultrasound is performed on a separate occasion to the procedure, benefits would be payable under the appropriate ultrasound item.

T4.7.2 Item [51312](#) provides a benefit for assistance by a medical practitioner at interventional techniques covered by Items [16606](#), [16609](#), [16612](#), [16615](#), [16627](#) and [16633](#).

EXAMINATION BY AN ANAESTHETIST (Group [T6](#))

T6.1 Pre-anaesthetic Consultations

T6.1.1 Before a procedure is decided upon, a practitioner may refer a patient to a specialist anaesthetist for a pre-anaesthesia consultation. Such an attendance will attract benefit as follows if,

- (i) as a result of the consultation, anaesthesia and surgery proceeded in the ordinary way, then Item [17603](#) applies;
- (ii) as a result of the consultation, the procedure is contra-indicated or is postponed for some days or weeks, this consultation, and any subsequent consultation by the anaesthetist during the postponement period, attracts benefits under the appropriate attendance item. In such a case, to qualify for the specialist rate of benefit, the patient must present a letter or note of referral by the referring doctor.

REGIONAL OR FIELD NERVE BLOCKS (Group [T7](#))

T7.1 General

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

T7.1.2

Where anaesthesia combines a regional nerve block with general anaesthesia for an operative procedure, benefit will be paid only under the relevant anaesthesia item as set out in Group [T10](#).

T7.1.3 Where a regional or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block attracts benefits under the Group [T10](#) anaesthesia item and not the block item in Group [T7](#).

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

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

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

T7.2 Maintenance of Regional or Field Nerve Block (Items [18222](#), [18225](#))

T7.2.1 Medicare benefit is attracted under these items only when the service is performed other than by the operating surgeon. This does not preclude benefits for an obstetrician performing an epidural block during labour.

T7.2.2 When the service is performed by the operating surgeon during the post-operative period of an operation it is considered to be part of the normal aftercare. In these circumstances a Medicare benefit is not attracted.

T7.3 Intrathecal or Epidural Injection (Item [18232](#))

T7.3.1 This item covers caudal infusion/injection.

T7.4 Destruction of Nerve Branch by Neurolytic Agent ([18292](#))

T7.4.1 This item includes the use of botulinus toxin as a neurolytic agent

T7.5 Intrathecal and Epidural Infusion

T7.5.1 Items [18226](#) and [18227](#) apply where intrathecal or epidural analgesia is required for obstetric patients in the after hours period. For these items, the after hours period is defined as the period from 8pm to 8am on any weekday, or any time on a Saturday, Sunday or a public holiday.

SURGICAL OPERATIONS (Group T8)

T8.1 General

T8.1.1 Many items in Group T8 of the Schedule are qualified by one of the following phrases: "as an independent procedure";

"not being a service associated with a service to which another item in this Group applies"; or "not being a service to which another item in this Group applies"

An explanation of each of these phrases is as follows.

T8.2 As an Independent Procedure

T8.2.1 The inclusion of this phrase in the description of an item precludes payment of benefits when:- (i) a procedure so qualified is associated with another procedure that is performed through the same incision, e.g. nephrostomy (Item [36552](#)) in the course of an open operation on the kidney for another purpose;

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

(iii) the procedure is an integral part of the performance of another procedure, e.g. removal of foreign body (Item [30067/30068](#)) in conjunction with debridement of deep or extensive contaminated wound of soft tissue, including suturing of that wound when performed under general anaesthetic (Item [30023](#)).

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

T8.3.1 "Not being a service associated with a service to which another item in this Group applies" means that benefit is not payable for any other item in that Group when it is performed on the same occasion as this item. eg item [30106](#). T8.3.2

"Not being a service associated with a service to which Item applies" means that when this item is performed on the same occasion as the reference item no benefit is payable. eg item [39330](#).

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

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

T8.5 Multiple Operation Formula

T8.5.1 The fees for two or more operations, listed in Group T8 (other than Subgroup 12 of that Group), performed on a patient on the one occasion (except as provided in paragraph T8.5.3) are calculated by the following rule:-

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

Note:

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

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

The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

For these purposes the term "operation" only refers to all items in Group T8 (other than Subgroup 12 of that Group).

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

T8.5.3

Where two medical practitioners operate independently and either performs more than one operation, the method of assessment outlined in paragraph T8.5.1 would apply in respect of the services performed by each medical practitioner.

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

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

T8.5.6 Where the need arises for the patient to be returned to the operating theatre on the same day as the original procedure for further surgery due to post-operative complications, which would not be considered as normal aftercare - see paragraph T8.5, such procedures would generally not be subject to the "multiple operation rule". Accounts should be endorsed to the effect that they are separate procedures so that a separate benefit may be paid.

T8.6 Procedure Performed with Local Infiltration or Digital Block

T8.6.1 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of

anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T8.7 Aftercare (Post-operative Treatment)

T8.7.1 Section 3(5) of the Health Insurance Act states that services included in the Schedule (other than attendances) include all professional attendances necessary for the purposes of post-operative treatment of the patient (for the purposes of this book, post-operative treatment is generally referred to as "after-care"). However, it should be noted that in some instances the after-care component has been specifically excluded from the item and this is indicated in the description of the item. In such cases benefits would be payable on an attendance basis where post-operative treatment is necessary. In other cases, where there may be doubt as to whether an item actually does include the after-care, this fact has been reinforced by the inclusion of the words "including after-care" in the description of the item.

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

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

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

T8.7.5 Some minor operations are merely stages in the treatment of a particular condition. Attendances subsequent to such operations should not be regarded as after-care but rather as a continuation of the treatment of the original condition and attract benefits. Items to which this policy applies are Items [30219](#), [30223](#), [32500](#), [34521](#), [34524](#), [38406](#), [38409](#), [39015](#), [41626](#), [41656](#), [42614](#), [42644](#), [42650](#) and [47912](#). Likewise, there are a number of services which may be performed during the aftercare period of procedures for pain relief which would also attract benefits. Such services would include all items in Groups [T6](#) and [T7](#) and Items [39013](#), [39100](#), [39115](#), [39118](#), [39121](#), [39127](#), [39130](#), [39133](#), [39136](#), [39324](#) and [39327](#).

T8.7.6 Where a patient has been operated on in a recognised hospital as a public patient (as defined in Section 3(1) of the Health Insurance Act), and where aftercare is directly related to the episode of admitted care for which the patient was treated free of charge as a public patient, the aftercare should be provided free of charge as part of the public hospital service. However, post-operative attendances by a private medical practitioner at a place other than the hospital may attract Medicare benefits on an attendance basis, subject to the hospital meeting its responsibilities under the 1998-2003 Australian Health Care Agreements relating to the provision of public hospital services.

T8.7.7 When a surgeon delegates after-care to a local doctor, Medicare benefit may be apportioned on the basis of 75% for the operation and 25% for the after-care. Where the benefit is apportioned between two or more medical practitioners, no more than 100% of the benefit for the procedure will be paid.

T8.7.8 In respect of fractures, where the after-care is delegated to a doctor at a place other than the place where the initial reduction is carried out, benefit may be apportioned on a 50:50 basis rather than on the 75:25 basis suggested for surgical operations.

T8.7.9 Where the reduction of a fracture is carried out by hospital staff in the out-patient or casualty department of a recognised hospital and the patient is then referred to a private practitioner for supervision of the after-care, Medicare benefits are payable for the after-care treatment on an attendance basis.

T8.7.10 The following table shows the period which has been adopted as reasonable for the after-care of fractures:-

(Note: This list is a guide only and each case should be judged on individual merits. See paragraphs T8.7.2 to T8.7.4 above.)

Treatment of fracture of	After-care Period
Terminal phalanx of finger or thumb	6 weeks
Proximal phalanx of finger or thumb	6 weeks
Middle phalanx of finger	6 weeks
One or more metacarpals not involving base of first carpometacarpal joint	6 weeks
First metacarpal involving carpometacarpal joint (Bennett's fracture)	8 weeks
Carpus (excluding navicular)	6 weeks
Navicular or carpal scaphoid	3 months
Colles'/Smith/Barton's fracture of wrist	3 months
Distal end of radius or ulna, involving wrist	8 weeks
Radius	8 weeks
Ulna	8 weeks
Both shafts of forearm or humerus	3 months
Clavicle or sternum	4 weeks
Scapula	6 weeks
Pelvis (excluding symphysis pubis) or sacrum	4 months
Symphysis pubis	4 months

Treatment of fracture of	After-care Period
Femur	6 months
Fibula or tarsus (excepting os calcis or os talus)	8 weeks
Tibia or patella	4 months
Both shafts of leg, ankle (Potts fracture) with or without dislocation, os calcis (calcaneus) or os talus	4 months
Metatarsals - one or more	6 weeks
Phalanx of toe (other than great toe)	6 weeks
More than one phalanx of toe (other than great toe)	6 weeks
Distal phalanx of great toe	8 weeks
Proximal phalanx of great toe	8 weeks
Nasal bones, requiring reduction	4 weeks
Nasal bones, requiring reduction and involving osteotomies	4 weeks
Maxilla or mandible, unilateral or bilateral, not requiring splinting	6 weeks
Maxilla or mandible, requiring splinting or wiring of teeth	3 months
Maxilla or mandible, circumosseous fixation of	3 months
Maxilla or mandible, external skeletal fixation of	3 months
Zygoma	6 weeks
Spine (excluding sacrum), transverse process or bone other than vertebral body requiring immobilisation in plaster or traction by skull calipers	3 months
Spine (excluding sacrum), vertebral body, without involvement of cord requiring immobilisation in plaster or traction by skull calipers	6 months
Spine (excluding sacrum), vertebral body, with involvement of cord	6 months

T8.8 Abandoned Surgery (Item [30001](#))

T8.8.1 Item [30001](#) applies where the procedure has been commenced but is then discontinued for medical reasons or for other reasons which are beyond the surgeon's control (eg equipment failure). Claims for benefits under this item should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T8.8.2 Where an abandoned procedure eligible for a benefit under item [30001](#) attracts an assistant under the provisions of the items listed in Group [T9](#) (Assistance at Operations), the fee for the surgical assistant is calculated as 50% of the assistance fee that would have applied under the relevant item from Group [T9](#).

T8.8.3 Practitioners claiming an assistant fee for abandoned surgery should itemise their accounts with the relevant item from Group [T9](#). Such claims should include an account endorsement "assistance at abandoned surgery" or similar and should be accompanied by full clinical details of the circumstances of the operation, including details of the surgery proposed and the reasons for the operation being discontinued.

T8.9 Repair of Wound (Items [30023](#) - [30049](#))

T8.9.1 The repair of wound referred to in these items must be undertaken by suture, tissue adhesive resin (such as methyl methacrylate) or clips. These items do not cover repair of wound at time of surgery.

T8.9.2 Item [30023](#) covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

T8.10 Drill Biopsy (Item [30078](#))

T8.10.1 Needle aspiration biopsy attracts benefit on an attendance basis and not under this item.

T8.11 Lipectomy, Wedge Excision - Two or More Excisions (Item [30171](#))

T8.11.1 Multiple lipectomies, e.g., both buttocks and both thighs attract benefits under Item [30171](#) once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction, except in the circumstances outlined in Items [45584](#) and [45585](#).

T8.12 Treatment of Keratoses, Warts etc (Items [30186](#), [30187](#), [30189](#), [30192](#), [36815](#))

T8.12.1 Treatment of keratoses, warts, etc. attract benefits on an attendance basis, with the exception of the treatment of warts and other premalignant skin lesions in the circumstances outlined in Items [30186](#), [30187](#), [30189](#), [30192](#) and [36815](#).

T8.12.2 The treatment of less than 10 premalignant skin lesions by galvanocautery, electrodesiccation or cryocautery also attracts benefits on an attendance basis.

T8.13 Cryotherapy and Serial Curettage Excision (Items [30196](#) - [30203](#))

T8.13.1 In Items [30196](#) and [30197](#), serial curettage excision, as opposed to simple curettage, refers to the technique where the margin having been defined, the lesion is carefully excised by a skin curette using a series of dissections and cauterisations so that all extensions and infiltrations of the lesion are removed.

T8.13.2 For the purposes of Items [30196](#) to [30203](#) (inclusive), the requirement for histopathological proof of malignancy is satisfied where multiple lesions are to be removed from the one anatomical region if a single lesion from that region is histologically tested and proven for malignancy.

T8.14 Telangiectases or Starburst Vessels (Items [30213](#), [30214](#))

T8.14.1 These items are restricted to treatment on the head and/or neck. A session of less than 20 minutes duration attracts benefits on an attendance basis.

T8.14.2 Item [30213](#) is restricted to a maximum of 6 sessions in a 12 month period. Where additional treatments are indicated in that period, Item [30214](#) should be used. Claims for benefits under Item [30214](#) should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.15 Dissection of Axillary Lymph Nodes (Items [30335](#), [30336](#))

T8.15.1 For the purposes of Items [30335](#) and [30336](#), the definitions of lymph node levels referred to are set out below.

T8.15.2 Anatomically, the dissection extends from below upwards as follows:

Level I - dissection of axillary lymph nodes up to the inferior border of pectoralis minor.

Level II - dissection of axillary lymph nodes up to the superior border of pectoralis minor.

Level III - dissection of axillary lymph nodes extending above the superior border of pectoralis minor.

T8.16 Laparotomy and Other Procedures (Item [30375](#))

T8.16.1 This item covers several operations on abdominal viscera not dissimilar in time and complexity. Where more than one of the procedures are performed during the one operation, each procedure may be itemised according to the multiple operation formula.

T8.17 Gastrointestinal endoscopic procedures (Items [30473-30481](#), [30484-30487](#), [30490-30494](#), [32084-32095](#))

T8.17.1 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

T8.17.2 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

T8.17.3 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.

T8.17.4 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 General Notes for Guidance).

T8.18 Gastrectomy, Sub-total Radical (Item [30523](#))

T8.18.1 The item differs from total radical Gastrectomy (Item [30524](#)) in that a small part of the stomach is left behind. It involves resection of the greater omentum and posterior abdominal wall lymph nodes with or without splenectomy.

T8.19 Anti-reflux Operations (Items [30527-30533](#), [31464](#), [31466](#))

T8.19.1 These items cover various operations for reflux oesophagitis. Where the only procedure performed is the simple closure of a diaphragmatic hiatus benefit would be attracted under Item [30387](#) (Laparotomy involving operation on abdominal viscera, including pelvic viscera, not being a service to which another item in this Group applies).

T8.20 Removal of Skin Lesions (Items [31200](#) - [31355](#))

T8.20.1 The excision of warts and seborrheic keratoses attracts benefits on an attendance basis. Pre-malignant lesions are covered by Items [31200](#) to [31240](#).

T8.20.2 The excision of suspicious pigmented and other skin lesions for diagnostic purposes attract benefits under Items [31205](#) to [31240](#). Only if a further more extensive excision is undertaken should the items covering excision of malignancies be used.

T8.20.3 Items [31200](#) and [31245](#) do not require specimen to be sent for histological confirmation. Items [31205](#) to [31240](#) and [31250](#) require that specimen be sent for histological examination. Items [31255](#) to [31335](#) require that specimen be sent for

histological confirmation of malignancy which must be received before itemisation of accounts for Medicare benefits purposes.
T8.20.4

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

T8.20.5 Item [31295](#) applies to the treatment of residual or recurrent BCCs or SCCs of the head and neck only, where performed by a specialist, or practitioner other than the practitioner who provided the previous treatment. Where the conditions of the item are not met, Items [31255](#) to [31290](#) are available to cover removal of residual or recurrent BCCs or SCCs.

T8.20.6 For the purposes of these items, the tumour/lesion size should be determined by the macroscopic measurement of the surface diameter of the tumour/lesion or, for elliptical tumours/lesions, by the average surface diameter. The relevant size of the lesion relates to that measured in situ before excision. Suture of wound following surgical excision also includes closure by tissue adhesive resin, clips or similar.

T8.20.7 Utilisation of the revised structure will be closely monitored and audited by the Health Insurance Commission to ensure appropriate usage of items. It will be necessary for practitioners to retain copies of histological reports.

T8.21 Removal of Skin Lesion From Face (Items [31235-31245](#), [31265-31275](#), [31310-31320](#))

T8.21.1 For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

T8.22 Dissection of lymph nodes of neck (Items [31423](#) to [31438](#))

T8.22.1 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.

T8.23 Excision of Breast Lesions, Abnormalities or Tumours - malignant or benign (Items [31500](#) - [31515](#))

T8.23.1 Therapeutic biopsy or excision of breast lesions, abnormalities or tumours under Items: [31500](#), [31503](#), [31506](#), [31509](#), [31512](#), [31515](#) either singularly or in combination should not be claimed when using the Advanced Breast Biopsy Instrumentation (ABBI) procedure, or any other large core breast biopsy device.

T8.24 Subcutaneous Mastectomy (Items [31524](#), [31527](#))

T8.24.1 When, after completing a subcutaneous mastectomy a prosthesis is inserted, benefits are payable for the latter procedure under Item [45527](#), the multiple operation formula applying.

T8.25 Fine Needle Aspiration of Breast Lesion (Item [31533](#))

T8.25.1 An impalpable lesion includes those lesions that clinically require definition by ultrasound or mammography for accurate or safe sampling, eg. lesions in association with breast prostheses or in areas of breast thickening.

T8.26. Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation (Items [31539](#), [31545](#))

T8.26.1 For the purposes of Items [31539](#) and [31545](#), Surgeons performing this procedure should have evidence of appropriate training via a course approved by the Breast Section of the Royal Australasian College of Surgeons, have experience in the procedure, and the Health Insurance Commission notified of their eligibility to perform this procedure.

T8.26.2 The ABBI procedure is contraindicated and should not be performed on the following subset of patients: -

- Patients with mass, asymmetry or clustered microcalcifications that cannot be targeted using digital imaging equipment;
- Patients unable to lie prone and still for 30 to 60 minutes;

- Breasts less than 20mm in thickness when compressed;
- Women on anticoagulants;
- Lesions that are too close to the chest wall to allow cannula access;
- Patients weighing more than 135kg;
- Women with prosthetic breast implants.

T8.27 Preoperative Localisation Of Breast Lesion Prior To The Use Of Advanced Breast Biopsy Instrumentation (Item [31542](#))

T8.27.1 For the purposes of item [31542](#), radiologists eligible to perform the procedure must have been identified by the Royal Australian and New Zealand College of Radiologists as having sufficient training and experience in this procedure, and the health insurance commission notified of their eligibility to perform this procedure.

T8.28 Varicose veins, Multiple Injections of (Items [32500](#), [32501](#))

T8.28.1 Item [32500](#) is restricted to a maximum of 6 treatments in a 12 month period. Where additional treatments are necessary in that period, Item [32501](#) applies. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.29 Endovascular repair of abdominal aortic aneurysm (Items [33116](#) and [33119](#))

T8.29.1 These items were introduced into the Schedule on an interim basis via Ministerial Determination under section 3C of the Health Insurance Act, following a recommendation of the Medicare Services Advisory Committee (MSAC). Interim funding is being provided to facilitate collection of Australian evidence of the medium term safety and effectiveness of these services. An audit of these services is being conducted by the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S). Continuation of funding is dependent on progress of the audit. Therefore providers of these services are strongly encouraged to take part in the audit. Further information on the review of these procedures and the audit is available from the MSAC Secretariat (see para 8.5 of the General Explanatory Notes).

T8.30 Arterial and Venous Patches (Items [33545-33551](#), [34815](#))

T8.30.1 Vascular surgery items have been constructed on the basis that arteriotomy and venotomy wounds are closed by simple suture without the use of a patch.

T8.30.2 Where a patch angioplasty is used to enlarge a narrowed vein, artery or arteriovenous fistula, the correct item would be [34815](#) or [34518](#). If the vein is harvested for the patch through a separate incision, Item [33551](#) would also apply, in accordance with the multiple operation rule.

T8.30.3 If a patch graft is involved in conjunction with an operative procedure included in Items [33500](#) - [33542](#), [33803](#), [33806](#), [33815](#), [33833](#) or [34142](#), the patch graft would attract benefits under Item [33545](#) or [33548](#) in addition to the item for the primary operation (under the multiple operation rule). Where vein is harvested for the patch through a separate incision Item [33551](#) would also apply.

T8.31 Embolectomy or Thrombectomy (Item [33806](#))

T8.31.1 Benefit is payable once only per extremity, regardless of the number of incisions required to access the artery or bypass graft.

T8.32 Peripheral Arterial or Venous Catheterisation (Item [35317](#))

T8.32.1 Item [35317](#) is restricted to the use of those chemotherapeutic agents other than antibiotic or antiviral agents.

T8.33 Colposcopic Examination (Item [35614](#))

T8.33.1 It should be noted that colposcopic examination (screening) of women during the course of a consultation does not attract Medicare benefits under Item [35614](#) except in the following circumstances:- (i) where the patient has had an abnormal cervical smear; (ii) where there is a history of ingestion of oestrogen by the patient's mother during her pregnancy; or (iii) where the patient has been referred by another medical practitioner because of suspicious signs of genital cancer.

T8.34 Hysteroscopy (Item [35626](#))

T8.34.1 Hysteroscopy undertaken in the office/consulting rooms can be claimed under this item where the conditions set out in the description of the item are met.

T8.35 Curettage of Uterus under GA or Major Nerve Block (Items [35639](#), [35640](#))

T8.35.1 Uterine scraping or biopsy using small curettes (e.g. Sharman's or Zeppelin's) and requiring minimal dilatation of the cervix, not necessitating a general anaesthesia, does not attract benefits under these items but would be paid under Item [35620](#) where malignancy is suspected, or otherwise on an attendance basis.

T8.36 Neoplastic Changes of the Cervix (Items [35644-35648](#))

T8.36.1 The term "previously confirmed intraepithelial neoplastic changes of the cervix" in these items refers to diagnosis made by either cytologic, colposcopic or histologic methods. This may also include persistent human papilloma virus (HPV) changes of the cervix.

T8.37 Sterilisation of Minors - Legal Requirements (Items [35657](#), [35687](#), [35688](#), [35691](#), [37622](#), [37623](#))

T8.37.1

- (i) It is unlawful throughout Australia to conduct a sterilisation procedure on a minor which is not a by-product of surgery appropriately carried out to treat malfunction or disease (eg malignancies of the reproductive tract) unless legal authorisation has been obtained.
- (ii) (Practitioners are liable to be subject to criminal and civil action if such a sterilisation procedure is performed on a minor (a person under 18 years of age) which is not authorised by the Family Court of Australia or another court or tribunal with jurisdiction to give such authorisation.
- (iii) Parents/guardians have no legal authority to consent on behalf of minors to such sterilisation procedures.
- (iv) Medicare Benefits are only payable for sterilisation procedures that are clinically relevant professional services as defined in Section 3 (1) of the Health Insurance Act 1973.

T8.38 Debulking of Uterus (Item [35658](#))

T8.38.1 Benefits are payable under Item [35658](#), using the multiple operation rule, in addition to vaginal hysterectomy.

T8.39 Selective Coronary Angiography (Items [38215-38246](#))

T8.39.1 Each item in the range [38215-38240](#) describes an episode of service. As such, only one item in this range can be claimed in a single episode.

T8.39.2 Item [38243](#) may be billed once only immediately prior to any coronary interventional procedure, including situations where a second operator performs any coronary interventional procedure after diagnostic angiography by the first operator.

T8.39.3 Item [38246](#) may be billed when the same operator performs diagnostic coronary angiography and then proceeds directly with any coronary interventional procedure during the same occasion of service. Consequently, it may not be billed in conjunction with items [38215](#), [38218](#), [38220](#), [38222](#), [38225](#), [38228](#), [38231](#), [38234](#), [38237](#), [38240](#) or [38243](#). In the event that the same operator performed any coronary interventional procedure immediately after the diagnostic procedure described by item 38231, 38237 or 38240, that item may be billed as an alternative to item 38246.

T8.39.4 Items in the range [38215](#) - [38246](#) cannot be claimed for any intravascular ultrasound (IVUS) procedure therefore Medicare Benefits are not payable for IVUS.

T8.40 Transurethral Needle Ablation (TUNA) of the Prostate

T8.40.1 Moderate to severe lower urinary tract symptoms are defined using the American Urological Association (AUA) Symptom Score or the International Prostate Symptom Score (IPSS).

T8.40.2 Patients not medically fit for transurethral resection of the prostate (TURP) can be defined as: (i)

Those patients who have a high risk of developing a serious complication from the surgery. Retrograde ejaculation is not considered to be a serious complication of TURP.

(ii) Those patients with a co-morbidity which may substantially increase the risk of TURP or the risk of the anaesthetic necessary for TURP.

T8.40.3 These items were introduced into the Schedule on an interim basis via Ministerial Determination under section 3C of the Health Insurance Act, following a recommendation of the Medical Services Advisory Committee (MSAC). Interim funding is being provided to facilitate collection of Australian evidence of the long term effectiveness, cost-effectiveness and safety of these services. Data collection and analysis is being conducted by the Australian Safety and Efficacy Register of New Interventional Procedures - Surgical (ASERNIP-S). Continuation of funding is dependent on the progress of this data collection. Therefore providers of these services are strongly encouraged to take part in the data collection process. Further information on the review of these items and the data collection process is available from the MSAC Secretariat (see para 8.5 of the General Explanatory Notes).

T8.41 Ureteroscopy (Item [36803](#))

T8.41.1 Item [36803](#) refers to ureteroscopy of one ureter when performed for the purpose of inspection alone. It may not be used when one of the other ureteroscopy numbers (Items [36806](#) or [36809](#)) or pyeloscopy numbers (Items [36652](#), [36654](#) or [36656](#)) is used for a ureteroscopic procedure performed in the same ureter or collecting system. It may be used when inspection alone is carried out in one ureter independently from a ureteroscopic or pyeloscopy procedure in another ureter or collecting system. If Item number [36803](#) is used with one of the other above 5 numbers, it must be specified that item number 36803 refers to ureteroscopy performed in another ureter eg [36654](#) (Right side) and [36803](#) (Left side). [36803](#) may also be used in this way if there is a partial or complete duplex collecting system eg [36809](#) (Lower pole moiety ureter, Left side) and [36803](#) (Upper pole moiety ureter, Left side).

T8.41.2 Item numbers [36806](#) and [36809](#) may only be used together when 2 independent ureteroscopic procedures are performed in separate ureters. These separate ureters may be components of a complete or partial duplex system. If both these numbers are used together, the Regulations require qualification of these item numbers by the site, as is necessary with [36803](#) eg [36806](#) (Right side) and [36809](#) (Left side).

T8.42 Brachytherapy of the Prostate (Item [37220](#))

T8.42.1 Brachytherapy treatment is only recommended for patients with a gland volume of less than or equal to 40cc and who have a life expectancy of at least 10 years.

T8.42.2 An approved site is one that has been licensed by the relevant Radiation Advisory Body.

T8.43 Radical or Debulking Operation for Ovarian Tumour including Omentectomy (Item [35720](#))

T8.43.1 This item refers to the operation for carcinoma of the ovary where the bulk of the tumour and the omentum are removed. Where this procedure is undertaken in association with hysterectomy benefits are payable under both item numbers with the application of the multiple operation formula.

T8.44 Cardiac Pacemaker Insertion (Items [38209](#), [38212](#), [38281](#), [38284](#))

T8.44.1 The fees for the insertion of a pacemaker (Items [38281](#) and [38284](#)) cover the testing of cardiac conduction or conduction threshold, etc related to the pacemaker and pacemaker function. Accordingly, additional benefits are not payable for such routine testing under Item [38209](#) or [38212](#) (Cardiac electrophysiological studies).

T8.45 Coronary Artery Bypass (Items [38497](#) - [38504](#))

T8.45.1 The fees for Items [38497](#) and [38498](#) include the harvesting of vein graft material. Harvesting of internal mammary artery and/or vein graft material is covered in the fees for Items [38500](#), [38501](#), [38503](#) and [38504](#). Where harvesting of an artery other than the internal mammary artery is undertaken, benefits are payable under Item [38496](#) on the multiple operation basis. The procedure of coronary artery bypass grafting using arterial graft is covered by Item [38500](#), [38501](#), [38503](#) or [38504](#) irrespective of the origin of the arterial graft.

T8.45.2 Items [38498](#), [38501](#) and [38504](#) require that either a clinical or medical perfusionist are present in the operating theatre throughout the procedure in case it is necessary to convert to an on-pump procedure and cardiopulmonary bypass is required.

T8.45.3

If it is necessary to provide cardiopulmonary bypass items [38498](#), [38501](#) and [38504](#) cannot be claimed. The procedure should be claimed under items [38497](#), [38500](#) or [38503](#) as appropriate in conjunction with the relevant cardiopulmonary bypass procedures.

T8.46 Re-operation via Median Sternotomy (Item [38640](#))

T8.46.1 Medicare benefits are payable for Item [38640](#) plus the item/s covering the major surgical procedure/s performed at the time of the re-operation, using the multiple operation formula. Benefits are not payable for Item [38640](#) in association with Item [38656](#), [38643](#) or [38647](#).

T8.47 Skull Base Surgery (Items [39640](#) - [39662](#))

T8.47.1 The surgical management of lesions involving the skull base (base of anterior, middle and posterior fossae) often requires the skills of several surgeons or a number of surgeons from different surgical specialties working together or in tandem during the operative session. These operations are usually not staged because of the need for definitive closure of the dura, subcutaneous tissues, and skin to avoid serious infections such as osteomyelitis and/or meningitis.

T8.47.2 Items [39640](#) to [39662](#) cover the removal of the tumour, which would normally be performed by a neurosurgeon. Other items are available to cover procedures performed as a part of skull base surgery by practitioners in other specialities, such as ENT and plastic and reconstructive surgery.

T8.48 Intradiscal Injection of Chymopapain (Item [40336](#))

T8.48.1 The fee for this item includes routine post-operative care. Associated radiological services attract benefits under the appropriate item in Group [I3](#).

T8.49 Removal of Ventilating Tube from Ear (Item [41500](#))

T8.49.1 Benefits are not payable under Item [41500](#) for removal of ventilating tube. This service attracts benefits on an attendance basis.

T8.50 Meatoplasty (Item [41515](#))

T8.50.1 When this procedure is associated with Item [41530](#), [41548](#), [41557](#), [41560](#) or [41563](#) the multiple operation rule applies.

T8.51 Reconstruction of Auditory Canal (Item [41524](#))

T8.51.1 When associated with Item [41557](#), [41560](#) or [41563](#) the multiple operation rule applies.

T8.52 Removal of Nasal Polyp or Polypi (Items [41662](#), [41665](#), [41668](#))

T8.52.1 Where such polyps are removed in association with another intranasal procedure, Medicare benefit is paid under Item [41662](#). However where the associated procedure is of lesser value than Items [41665/41668](#), benefit for removal of polypi would be paid under Items [41665/41668](#).

T8.53 Larynx, Direct Examination (Item 41846)

T8.53.1 Benefit is not attracted under this item when an anaesthetist examines the larynx during the course of administration of a general anaesthetic.

T8.54 Microlaryngoscopy (Item 41858)

T8.54.1 This item covers the removal of "juvenile papillomata" by mechanical means, e.g. cup forceps. Item 41861 refers to the removal by laser surgery.

T8.55 Refractive Keratoplasty (Item 42671)

T8.55.1 The description of this item refers to two sets of calculations, one performed some time prior to the operation, the other during the course of the operation. Both of these measurements are included in the Schedule fee and benefit for Item 42671.

T8.56 Capsulectomy or Lensectomy (Item 42731)

T8.56.1 The following items would be regarded as intraocular operations, and should not be itemised with Item 42731:

42551	42554	42557	42560	42563	42566	42569
42698	42701	42702	42703	42704	42707	42716
42734	42743	42746	42761	42764	42767	42815
42857						

T8.56.2 This list of exclusions was developed following consultation with the Royal Australian College of Ophthalmologists.

T8.57 Cyclodestructive Procedures (Items 42770 and 42771)

T8.57.1 Item 42770 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period item 42771 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in-Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.58 Laser Trabeculoplasty (Items 42782, 42783)

T8.58.1 Item 42782 is restricted to a maximum of 4 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42783 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.59 Laser Iridotomy (Items 42785, 42786)

T8.59.1 Item 42785 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42786 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.60 Laser Capsulotomy (Items 42788, 42789)

T8.60.1 Item 42788 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42789 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.61 Laser Vitreolysis or Corticolysis of lens material or Fibrinolysis (Items 42791, 42792)

T8.61.1 Item 42791 is restricted to a maximum of 2 treatments in a 2 year period. Where additional treatments are necessary in that period Item 42792 should be utilised. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.6 of the General Explanatory Notes.)

T8.62 Division of Suture by Laser (Item [42794](#))

T8.62.1 Benefits under this item are restricted to a maximum of 2 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.63 Laser Coagulation of Corneal or Scleral Blood Vessels (Item [42797](#))

T8.63.1 Benefits under this item are restricted to 4 treatments in a 2 year period. There is no provision for additional treatments in that period.

T8.63.2 Benefits are not payable under Item [42797](#) for procedures undertaken for cosmetic purposes (see paragraph [T13.1.2](#) of the General Explanatory Notes).

T8.64 Readjustment of Adjustable Sutures (Item [42845](#))

T8.64.1 This item refers to the occasion when readjustment has to be made to the sutures to vary the angle of deviation of the eye. It does not cover the mere tightening of the loosely tied sutures without repositioning.

T8.65 Full Face Chemical Peel (Items [45019](#), [45020](#))

T8.65.1 These items relate to full-face chemical peel in the circumstances outlined in the item descriptors. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment of benefits have been met. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.66 Abrasive therapy/Resurfacing (Items [45021](#) - [45026](#))

T8.66.1 For the purposes of the above items, one aesthetic area is any of the following of the whole face (considered to be divided into six segments):- forehead; right cheek; left cheek; nose; upper lip; and chin.

T8.66.2 Items [45021](#) and [45024](#) cover abrasive therapy only. Services performed using a laser are not eligible for benefits under these items.

T8.67 Foreign Implant (Item [45051](#))

T8.67.1 For Medicare benefits to be payable for this item the intention of the implantation must be either to reconstruct facial or body contours which have been damaged by trauma or disease or to correct a deformity which has been pathologically caused.

T8.68 Escharotomy (Item [45054](#))

T8.68.1 Benefits are payable once only under Item [45054](#) for each limb (or chest) regardless of the number of incisions to each of these areas.

T8.69 Local Skin Flap - Definition

T8.69.1 A local skin flap is an area of skin and subcutaneous tissue designed to be elevated from the skin adjoining a defect requiring closure. The flap remains partially attached by its pedicle and is moved into the defect by rotation, advancement or transposition, or a combination of these manoeuvres. A benefit is only payable when the flap is required for adequate wound closure. A secondary defect will be created which may be closed by direct suture, skin grafting or sometimes a further local skin flap. This later procedure will also attract benefit if closed by graft or flap repair but not when closed by direct suture.

T8.69.2 By definition, direct wound closure (e.g. by suture) does not constitute skin flap repair. Similarly, angled, curved or trapdoor incisions which are used for exposure and which are sutured back in the same position relative to the adjacent tissues are not skin flap repairs. Undermining of the edges of a wound prior to suturing is considered a normal part of wound closure and is not considered a skin flap repair.

T8.69.3 A "Z" plasty is a particular type of transposition flap repair. Although 2 flaps are created, benefit will be paid on the basis of Items [45200](#), [45203](#) or [45206](#) once only.

T8.69.4 Items where benefit for local skin flap repair (if indicated as above) is payable, include:

[30023](#), [30180](#), [30186](#), [30269](#), [31200-31340](#), [45030](#), [45033](#), [45036-45045](#), [45506](#), [45512](#), [45626](#)

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

T8.69.5 The following items are examples of where local flap repair would usually not be payable. If further advice is required the Health Insurance Commission should be contacted.

[30026-30052](#), [30099-30114](#), [30165-30177](#), [45520](#), [45522](#), [45524](#), [45563](#), [45587](#), [45632-45644](#), [45659](#), [45662](#), [45677-45713](#).

T8.70 Free grafting to burns (Items [45406](#) - [45418](#))

T8.70.1 Items [45406](#) to [45418](#) cover split skin grafting using autografts, homografts or xenografts.

T8.71 Augmentation Mammoplasty (Items [45524](#), [45527](#), [45528](#))

T8.71.1 Medicare benefit is generally not attracted under Item [45524](#) unless the asymmetry in breast size is greater than 10%. Augmentation of a second breast some time after an initial augmentation of one side would not attract benefits. Benefits are not payable for augmentation mammoplasty in association with correction of breast ptosis (Items [45556](#), [45557](#) and [45558](#)).

T8.71.2 Item [45528](#) applies where bilateral mammoplasty is indicated because of disease, trauma or congenital malformation (other than covered under Item [45524](#) or [45527](#)). Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.72 Breast Reconstruction, Myocutaneous Flap (Item [45530](#))

T8.72.1 When a prosthesis is inserted in conjunction with this operation, benefit would be attracted under Item [45527](#), the multiple operation rule applying. Benefits would also be payable for nipple reconstruction (Item [45545](#)) when performed. T8.72.2

When a rectus abdominus flap is used, secondary repair of the muscle defect by an external oblique muscle flap would be covered under Item [45012](#). However, where the repair is by Teflon or similar mesh, Item [30405](#) should be itemised.

T8.73 Breast Ptosis (Items [45556](#), [45557](#) and [45558](#))

T8.73.1 For the purposes of Item [45556](#), Medicare benefit is only payable for the correction of breast ptosis when performed unilaterally, to match the position of the contralateral breast. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

T8.73.2 Items [45557](#) and [45558](#) apply where correction of breast ptosis is indicated because the nipple is inferior to the inframammary groove. Claims for benefits should be accompanied by full clinical details including colour photographs. Where digital photographs are supplied they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.74 Nipple and/or Areola Reconstruction (Item [45545](#), [45546](#))

T8.74.1 Item [45545](#) involves the taking of tissue from, for example, the other breast, the ear lobe and the inside of the upper thigh with or without local flap.

T8.74.2 Item [45546](#) covers the non-surgical creation of nipple or areola by intradermal colouration.

T8.75 Liposuction (Items [45584](#), [45585](#))

T8.75.1 Medicare benefits for liposuction are generally attracted under Item [45584](#), that is, for the treatment of post traumatic pseudolipoma. Such trauma must be significant and result in large haematoma and localised swelling. Only on very rare occasions would benefits be payable for bilateral liposuction.

T8.75.2 Where liposuction is indicated for the treatment of conditions such as pathological lipodystrophy of hips, buttocks, thighs and lower legs (including knees), gynaecomastia and lymphoedema, Item [45585](#) applies. Claims for benefits under this item should be accompanied by full clinical details, including full body pre-operative photographs. Where digital photographs are supplied, they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.76 Meloplasty for Correction of Facial Asymmetry (Items [45587](#), [45588](#))

T8.76.1 Benefits are payable under Item [45587](#) for unilateral face-lift operations performed to correct soft tissue abnormalities of the face due to causes other than the ageing process.

T8.76.2 Where bilateral meloplasty is indicated because of disease, trauma or congenital malformation for conditions such as drooping from the angles of the mouth and deep pitting of the skin due to acne scars Item [45588](#) applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.77 Reduction of Eyelids (Items [45617](#), [45620](#))

T8.77.1 Where a reduction is performed for a medical condition of one eyelid, it may be necessary to undertake a similar compensating procedure on the other eyelid to restore symmetry. The latter operation would also attract benefits. Where there is doubt as to whether benefits would be payable, advice should be sought from a medical adviser of the Health Insurance Commission.

T8.78 Rhinoplasty ([45638](#), [45639](#))

T8.78.1 Benefits are payable for septoplasty (Item [41671](#)) where performed in conjunction with rhinoplasty.

T8.78.2 Item [45639](#) applies where surgery is indicated for the correction of significant developmental deformity.

Developmental deformity includes cleft nose, bifid tip and twisted nose. Claims for benefits under this item should be accompanied by full clinical details and pre-operative photographs, including front, base (ie inferior view) and two laterals of the nose. Where digital photographs are supplied, they must also be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

T8.79 Vermilionectomy (Item [45669](#))

T8.79.1 Item [45669](#) covers treatment of the entire lip.

T8.80 Osteotomy of Jaw (Items [45720](#) - [45752](#))

T8.80.1 The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, eg iliac crest, would attract additional benefit under Item [47726](#) or [47729](#) for the harvesting, plus Item [48239](#) or [48242](#) for the grafting.

T8.80.2 For the purposes of these items, a reference to maxilla includes the zygoma.

T8.81 Genioplasty (Items [45761](#))

T8.81.1 Genioplasty attracts benefit once only although a section is made on both sides of the symphysis of the mandible.

T8.82 Reduction of Dislocation or Fracture

T8.82.1 Closed reduction means treatment of a dislocation or fracture by non-operative reduction, and includes the use of percutaneous fixation or external splintage by cast or splints.

T8.82.2 Open reduction means treatment of a dislocation or fracture by either operative exposure including the use of any internal or external fixation; or non-operative (closed reduction) where intra-medullary or external fixation is used.

T8.82.3 Where the treatment of a fracture requires reduction on more than one occasion to achieve an adequate alignment, benefits are payable for each separate occasion at which reduction is performed under the appropriate item covering the fracture being treated.

T8.82.4 The treatment of fractures/dislocations not specifically covered by an item in Subgroup 15 (Orthopaedic) attracts benefits on an attendance basis.

T8.83 Internal Fixation (Items [48678](#)-[48690](#))

T8.83.1 Benefits under these items are only attracted where internal fixation is carried out in association with spinal fusion covered by Items [48642](#) to [48675](#). The multiple rule would apply in each instance.

T8.84 Wrist Surgery (Items [49200](#)-[49227](#))

T8.84.1 For the purposes of these items, the wrist includes both the radiocarpal joint and the midcarpal joint.

T8.85 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items [50124](#), [50125](#))

T8.85.1 Item [50124](#) is restricted to a maximum of 25 treatments in a 12 month period. Where additional treatments are necessary Item [50125](#) applies. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. Where digital photographs are supplied, they must be accompanied by polaroid photographs. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note [8.6](#) of the General Explanatory Notes.)

ASSISTANCE AT OPERATIONS (Group [T9](#))

T9.1 General

T9.1.1 Items covering operations which are eligible for benefits for surgical assistance have been identified by the inclusion of the word "Assist." in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

T9.1.2 The assistance must be rendered by a medical practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

T9.1.3 Where more than one practitioner provides assistance to a surgeon no additional benefits are payable. The assistance benefit payable is the same irrespective of the number of practitioners providing surgical assistance.

T9.2 Benefits payable under Item [51300](#)

T9.2.1 Medicare benefits are payable under item [51300](#) for assistance rendered at any operation identified by the word "Assist." for which the fee does not exceed the fee threshold specified in the item descriptor, or at a series or combination of operations identified by the word "Assist." for which the aggregate Schedule fee threshold specified in the item descriptor has not been exceeded.

T9.3 Benefits payable under item [51303](#)

T9.3.1 Medicare benefits are payable under item [51303](#) for assistance rendered at any operation identified by the word "Assist." for which the fee exceeds the fee threshold specified in the item descriptor or at a series or combination of

operations identified by the word "Assist." for which the aggregate Schedule fee exceeds the threshold specified in the item descriptor.

T9.4 Benefits Payable Under Item [51309](#)

T9.4.1 Medicare benefits are payable under item [51309](#) for assistance rendered at any operation identified by the word "Assist." or a series or combination of operations identified by the word "Assist." and assistance at a delivery involving Caesarean section.

T9.4.2 Where assistance is provided at a Caesarean section delivery and at a procedure or procedures which have not been identified by the word "Assist.", benefits are payable under item [51306](#).

T9.5 Assistance at Multiple Operations

T9.5.1 Where surgical assistance is provided at two or more operations performed on a patient on the one occasion the multiple operation formula is applied to all the operations to determine the surgeon's fee for Medicare benefits purposes. The multiple-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for surgical assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Item [51300](#) or [51303](#)).

Example.

Multiple Operation Rule - Surgeon

Item A - \$300@100%

Item B - \$250@50%

Item C - \$200@25%

Item D - \$150@25%

Multiple Operation Rule - Assistant

Item A(Assist.) - \$300@100%

Item B(No Assist.) -

Item C(Assist.) - \$200@50%

Item D(Assist.) - \$150@25%

T9.5.2 The derived fee applicable to Item [51303](#) is calculated on the basis of one-fifth of the abated Schedule fee for the surgery which attracts an assistance rebate.

T9.6 Surgeons Operating Independently

T9.6.1 Where two surgeons operate independently (ie neither assists the other or administers the anaesthetic) the procedures they perform are considered as two separate operations, and therefore, where a surgical assistant is engaged by each, or one of the surgeons, benefits for surgical assistance are payable in the same manner as if the surgeons were operating separately.

T9.7 Assistance at Cataract and Intraocular Lens Surgery

T9.7.1 The reference to "previous significant surgical complication" covers vitreous loss, rupture of posterior capsule, loss of nuclear material into the vitreous, intraocular haemorrhage, intraocular infection (endophthalmitis), cystoid macular oedema, corneal decompensation or retinal detachment.

RELATIVE VALUE GUIDE FOR ANAESTHESIA (Group [T10](#))

For a trial period of two years commencing 1 November 2001, the Relative Value Guide (RVG) for Anaesthesia has been introduced into the Medicare Benefits Schedule under a cost neutral framework, as the basis for calculating Medicare benefits for anaesthesia services. This follows a feasibility study commissioned by the Commonwealth and guided jointly with the profession and extensive consultation with representatives of the Australian Society of Anaesthetists, the Australian Medical Association and the Rural Doctors Association of Australia.

T10.1 Overview of the RVG

T10.1.1 The RVG groups anaesthesia services within anatomical regions. These items are listed in the MBS under Group T10, Subgroups 1-16 Anaesthesia for radiological and other therapeutic and diagnostic services are grouped separately under Subgroup 17. Also included in the RVG format are certain additional monitoring and therapeutic services, such as blood pressure monitoring (item [22012](#)) and central vein catheterisation (item [22020](#)) when performed in association with the administration of anaesthesia (see Note [T10.7](#)). These services are listed at subgroup 19. The RVG also provides for assistance at anaesthesia under certain circumstances (see point [T10.8](#)). These items are listed at subgroup 26.

T10.1.2 Details of the RVG are also available at the following website address, which includes a section answering "frequently asked questions" about the new arrangements: www.health.gov.au/haf/rvg/index.htm

T10.1.3 The RVG is based on an anaesthesia unit system reflecting the difficulty of the service and the total time taken for the service. Each unit has been assigned a dollar value.

T10.1.4 Under the RVG, the Medicare benefit for anaesthesia in connection with a procedure is comprised of up to three components:

The basic units allocated to each anaesthetic procedure, reflecting the degree of difficulty of the procedure (an item in the range [20100-21997](#)), for example:

	INITIATION AND MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units)
20702	Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10

the time unit allocation reflecting the **total time** of the anaesthesia (an item in the range [23010-24136](#)), for example;

	- 41 MINUTES to 45 MINUTES (3 units)
23033	Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10

plus, where appropriate

modifying units recognising certain added complexities in anaesthesia (an item/s in the range [25000-25020](#)), for example

	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA where the patients age is less than 12 months of age or 70 years or greater (1 unit)
25015	Fee: \$16.50 Benefit: 75% = \$12.40 85% = \$14.05

T10.1.5 Each assistant at anaesthesia service in subgroup 26 has also been allocated a number of base units. The total time that the assistant anaesthetist was in active attendance on the patient is then added, along with modifiers, as appropriate, to establish the fee for the assistant service. For example:

	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment , to the exclusion of all other patients
25200	Derived Fee: An amount of \$82.50 (5 basic units) plus an item in the range 23010-24136) plus, where applicable, an item/s in the range 25000 - 25020

T10.1.6 As with anaesthesia, where whole body perfusion is performed, the Schedule fee is determined on the base units allocated to the service (item [22060](#)), the total time for the perfusion, and modifying units, as appropriate i.e

(a) the basic units allocated to whole body perfusion under item [22060](#);

	WHOLE BODY PERFUSION, CARDIAC BYPASS , using heart-lung machine or equivalent (20 basic units)
22060	(See para T10.9 of explanatory notes to this Category) Fee: \$330.00 Benefit: 75% = \$247.50 85% = \$280.50

(b) plus, the **time** unit allocation reflecting the **total time** of the perfusion (an item in the range [23010 - 24136](#)), for example;

	41 MINUTES TO 45 MINUTES (3 basic units)
23033	Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10

plus, where appropriate

(c) **modifying** units recognising certain added complexities in perfusion (an item/s in the range [25000 - 25020](#)) for example

	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient's age is up to one year or 70 years or greater (1 basic units)
25015	Fee: \$16.50 Benefit: 75% = \$12.40 85% = \$14.05

T10.2 Eligible Services

T10.2.1 With some exceptions (see note [T10.13](#)), a Medicare benefit is only payable for anaesthesia which is performed in connection with an “eligible” service. Under the Health Insurance Regulations, an “eligible” service is defined as a clinically relevant professional service (as outlined in paragraph [1.1.4](#) of the General Explanatory Notes of the Medicare Benefits Schedule) which is listed in the Schedule and which has been identified as attracting an anaesthetic fee.

T10.3 RVG Unit Values

Basic Units

T10.3.1 The RVG basic unit allocation represents the degree of difficulty of the anaesthetic procedure relative to the anatomical site and physiological impact of the surgery.

Time Units

T10.3.2 The number of time units is calculated from the total time of the anaesthesia service, the assistant at anaesthesia service or the whole body perfusion service:

- **for anaesthesia**, time is considered to begin when the anaesthetist commences exclusive and continuous care of the patient for anaesthesia. Time ends when the anaesthetist is no longer in professional attendance, that is, when the patient is safely placed under the supervision of other personnel;
- **for assistance at anaesthesia**, time is taken to be the period that the assistant anaesthetist is in active attendance on the patient during anaesthesia; and
- **for perfusion**, perfusion time begins with the commencement of anaesthesia and finishes with the closure of the chest.

T10.3.3 For up to and including the first 4 hours of time, each 15 minutes (or part thereof) constitutes 1 time unit. For time beyond 4 hours, each time unit equates to 10 minutes (or part thereof).

T10.3.4 For statistical purposes, the first 2 hours of time after the first 15 minutes is represented in the Medicare Benefits Schedule by item numbers in 5 minute increments.

For example:

	ANAESTHESIA, ASSISTANCE AT ANAESTHESIA OR PERFUSION TIME for anaesthesia in connection with an eligible medical service or a dental service or assistance at anaesthesia in connection with an eligible medical service or for perfusion in connection with an eligible medical service		
23010	15 MINUTES OR LESS (1 unit) Fee: \$16.50	Benefit: 75%= \$12.40	Benefit: 85% = \$14.05
23021	16 MINUTES TO 20 MINUTES (2 units) Fee: \$33.00	Benefit: 75%= \$24.75	Benefit: 85% = \$28.05
23022	21MINUTES to 25 MINUTES (2 units) Fee: \$33.00	Benefit: 75%= \$24.75	Benefit: 85% = \$28.05
23023	26 MINUTES to 30 MINUTES (2 units) Fee: \$33.00	Benefit: 75%= \$24.75	Benefit: 85% = \$28.05
23031	31 MINUTES to 35 MINUTES (3 units) Fee: \$49.50	Benefit: 75%= \$37.15	Benefit: 85% = \$42.10
23032	36 MINUTES to 40 MINUTES (3 units) Fee: \$49.50	Benefit: 75%= \$37.15	Benefit: 85% = \$42.10
23033	41 MINUTES to 45 MINUTES (3 units) Fee: \$49.50	Benefit: 75%= \$37.15	Benefit: 85% = \$42.10

T10.3.5 For services lasting between 15 minutes and two hours, the appropriate 5 minute item number should be included on accounts.

Modifying Units ([25000](#) - [25050](#))

T10.3.6 Modifying units have been included in the RVG to recognise added complexities in anaesthesia or perfusion, associated with the patient’s age, physical status or the requirement for emergency surgery. These cover the following clinical situations:

ASA physical status indicator 3 - A patient with severe systemic disease that significantly limits activity (item 25000). This would include: severely limiting heart disease; severe diabetes with vascular complications or moderate to severe degrees of pulmonary insufficiency.

Some examples of clinical situations to which ASA 3 would apply are: -

- a patient with ischaemic heart disease such that they encounter angina frequently on exertion thus significantly limiting activities;
- a patient with chronic airflow limitation who gets short of breath such that the patient cannot complete one flight of stairs without pausing;
- a patient who has suffered a stroke and is left with a residual neurological deficit to the extent that is significantly limits normal activity, such as hemiparesis; or
- a patient who has renal failure requiring regular dialysis.

ASA physical status indicator 4 - A patient with severe systemic disease which is a constant threat to life (item 25005). This covers patients with severe systemic disorders that are already life-threatening, not always correctable by an operation. This would include: patients with heart disease showing marked signs of cardiac failure; persistent angina or advanced degrees of pulmonary, hepatic, renal or endocrine insufficiency.

ASA physical status indicator 4 would be characterised by the following clinical examples: -

- a person with coronary disease such that they get angina daily on minimum exertion thus severely curtailing their normal activities;
- a person with end stage emphysema who is breathless on minimum exertion such as brushing their hair or walking less than 20 metres; or
- a person with severe diabetes which affects multiple organ systems where they may have one or more of the following examples:-
- severe visual impairment or significant peripheral vascular disease such that they may get intermittent claudication on walking less than 20 metres; or
- severe coronary artery disease such that they suffer from cardiac failure and/or angina whereby they are limited to minimal activity.

ASA physical status indicator 5 - a moribund patient who is not expected to survive for 24 hours with or without the operation (item 25010). This would include: a burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure or massive pulmonary embolus.

The following are some examples that would equate to ASA physical status indicator 5 -

- a burst abdominal aneurysm with profound shock;
- major cerebral trauma with increasing intracranial pressure; or
- massive pulmonary embolus.

NOTE: It should be noted that the Medicare Benefits Schedule does NOT include modifying units for patients assessed as ASA physical status indicator 2.

Some examples of ASA 2 would include: -

- a patient with controlled hypertension which has no affect on the patient's normal lifestyle;
- a patient with coronary artery disease that results in angina occurring on substantial exertion but not limiting normal activity; or
- a patient with insulin dependant diabetes which is well controlled and has minimal effect on normal lifestyle.”

Where the patient is less than 12 months or age or 70 years or greater (item 25015).

For anaesthesia, assistance at anaesthesia or a perfusion service in association with an *emergency procedure (item 25020).

For anaesthesia or assistance at anaesthesia in association with an *after hours emergency procedure (items 25025 and 25030).

For a perfusion service in association with *after hours emergency surgery (item 25050).

*** NOTE: It should be noted that the emergency modifier and the after hours emergency modifiers cannot both be claimed in the one anaesthesia assistance at anaesthesia or perfusion episode.**

T10.3.7 It should also be noted that modifiers are not stand alone services and can only be claimed in association with anaesthesia, assistance at anaesthesia or with a perfusion service covered by item 22060.

Definition of Emergency T10.3.8

For the purposes of both the emergency modifier and the after hours emergency modifiers, emergency is defined as being where the patient requires immediate treatment without which there would be significant threat to life or body part.

Definition of After Hours T10.3.9

For the purposes of the after hours emergency modifier items, the after hours period is defined as being the period from 8pm to 8am on any weekday or at any time on a Saturday, a Sunday or a public holiday. Benefit for the After Hours Emergency Modifiers is only payable where more than 50% of the time for the emergency anaesthesia, the assistance at emergency anaesthesia or the perfusion service is provided in the after hours period. In situations where less than the 50% of the time for the service falls in the after hours period, the emergency modifier rather than the after hours emergency modifier applies. For information about deriving the fee for the service where the after hours emergency modifier applies see point T10.4.2.

T10.4 Deriving the Schedule Fee under the RVG

T10.4.1 The Schedule fee for each component of anaesthesia (base items, time items and modifier items) in the RVG Schedule was derived by applying the unit value to the total number of anaesthesia units for each component. For example:

ITEM	DESCRIPTION		SCHEDULE FEE
17603	Pre-anaesthesia Consultation		\$34.80
RVG	Anaesthesia Service	Units	Schedule Fee (Units X \$16.50)
20840	Anaesthesia for resection of perforated bowel		\$99.00
23190	Time - 4 hours 30minutes	19	\$313.50
25000	Modifier - Physical status	1	\$16.50
22012	Central Venous Pressure Monitoring	3	\$49.50

T10.4.2 After Hours Emergency Services

When deriving the fee for the after hours emergency modifier for anaesthesia or assistance at anaesthesia, the 50% loading applies to the anaesthesia or assistance service from Group T10 and to any additional clinically relevant therapeutic or diagnostic service from Group T10, Subgroup 18, provided during the anaesthesia episode. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE (UNITS X \$16.50)
20840	Anaesthesia for resection of perforated bowel	6	\$99.00
23190	Time - 4 hours 30minutes	19	\$313.50
25000	Modifier - Physical status	1	\$16.50
22012	Central Venous Pressure Monitoring	3	\$49.50
	TOTAL UNITS	=29	Schedule fee = \$478.50
25025	Anaesthesia After Hours Emergency Modifier		Schedule fee = \$478.50 x 50% = \$239.25

T10.4.3 Definition of Radical Surgery

Where the term radical appears in an item description, it refers to an extensive surgical procedure, performed for the treatment of malignancy. It usually denotes extensive block dissection not only of the malignant tissue, but also of the surrounding tissue, particularly fat and lymphatic drainage systems.

T10.4.4 Multiple Anaesthesia Services

T10.4.4.1 Where anaesthesia is provided for services covered by multiple items in the RVG, Medicare benefit is only payable for the RVG item with the highest basic unit value. However, the time component should include the total anaesthesia time taken for all services. For example:

ITEM	DESCRIPTION	UNITS	SCHEDULE FEE
20790	Anaesthesia for Cholecystectomy	7	\$132.00
20752	Incisional Hernia	6	\$99.00
23100	Time - 2hrs 30mins	10	\$165.00
25015	Physical Status - Over 70	1	\$16.50

10.4.5 Prolonged Anaesthesia

T10.4.5.1 Under the RVG, the previous rules that related to prolonged anaesthesia no longer apply. Where anaesthesia is prolonged beyond that which an anaesthetist would normally encounter for a particular service, the RVG provides for the anaesthetist to claim the total anaesthesia time for the procedure/s.

T10.5 Account Requirements

T10.5.1 Before benefit will be paid for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out at paragraph 7.1 of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule are required on the anaesthetist's account:

- the anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. As well, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and total time of the anaesthetic.
- the assistant anaesthetist's account must show the names/s of the medical practitioners who performed the associated operation/s, as well as the name of the principal anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthetic.
- The perfusionist's account must record the start time, end time and total time of the perfusion service where the after hours emergency modifier is claimed.

T10.6 General Information

T10.6.1 The Health Insurance Act provides that where anaesthesia is administered to a patient, the premedication of the patient in preparation for anaesthesia is deemed to form part of the administration of anaesthesia. The administration of anaesthesia also includes the pre-anaesthesia consultation with the patient in preparation for that administration, except where such consultation entails a separate attendance carried out at a place other than an operating theatre or an anaesthesia induction room. The pre-anaesthesia consultation for a patient should be performed in association with a clinically relevant service.

T10.6.2

Except in special circumstances, benefit is not payable for the administration of anaesthesia listed in Subgroups 1- 18, unless the anaesthesia is administered by a medical practitioner other than the medical practitioner who renders the medical service in connection with which anaesthesia is administered.

T10.6.3 Fees and benefits for anaesthesia services under the RVG cover all essential components in the administration of the anaesthesia service. Separate benefit may be attracted, however, for complementary services such as central venous pressure and direct arterial pressure monitoring (see note T10.7).

It should be noted that additional benefit is not payable for intravenous infusion or electrocardiographic monitoring, provision for which has been made in the value determined for the anaesthetic units.

T10.6.4 The Medicare benefit derived under the RVG for the administration of anaesthesia is the benefit payable for that service irrespective of whether one or more than one medical practitioner administers it. However, benefit is provided under Subgroup 24 for the services of one assistant anaesthetist (who must not be either the surgeon or assistant surgeon (see Note 10.8)

T10.6.5

Where a regional nerve block or field nerve block is administered by a medical practitioner other than the practitioner carrying out the operation, the block is assessed as an anaesthesia item according to the advice in paragraph T10.4. When a block is carried out in cases not associated with an operation, such as for intractable pain or during labour, the service falls under Group T7.

T10.6.6 When a regional nerve block or field nerve block covered by an item in Group T7 of the Schedule is administered by a medical practitioner in the course of a surgical procedure undertaken by him/her, then such a block will attract benefit under the appropriate item in Group T7.

T10.6.7 It is to be noted that where a procedure is carried out with local infiltration or digital block as the means of anaesthesia, that anaesthesia is considered to be part of the procedure and an additional benefit is therefore not payable.

T10.6.8 It may happen that the professional service for which the anaesthesia is administered does not itself attract a benefit because it is part of the after-care of an operation. This does not, however, affect the benefit payable for the anaesthesia service. Benefit is payable for anaesthesia administered in connection with such a professional service (or combination of services) even though no benefit is payable for the associated professional service.

T10.6.9 The administration of epidural anaesthesia during labour is covered by Item 18216 or 18219 in Group T7 of the Schedule whether administered by the medical practitioner undertaking the confinement or by another medical practitioner. Subsequent "top-ups" are covered by Item 18222 or 18225.

T10.7 Additional Services performed in connection with Anaesthesia- Subgroup 19

T10.7.1 Included in the RVG format are a number of additional or complimentary services which may be provided in connection with anaesthesia such as pulmonary artery pressure monitoring (item 22012) and intra-arterial cannulation (item 22025).

T10.7.2 These items (with the exception of peri-operative nerve blocks (22030-22050)) and perfusion services (22055-22075) have also been retained in the MBS in the non-RVG format, for use by practitioners who provide these services other than in association with anaesthesia.

T10.7.3 Where an anaesthetist provides an additional (clinically relevant) service during anaesthesia that is not one listed in

Subgroup 19 (excluding intravenous infusion or electrocardiographic monitoring) the relevant non-RVG item should be claimed.

T10.8 Assistance in the Administration of Anaesthesia (Items [25200](#) and [25205](#))

T10.8.1 The RVG provides for a separate benefit to be paid for the services of an assistant anaesthetist in connection with an operation or series of operations in specified circumstances, as outlined below. This benefit is payable only in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

T10.8.2 Assistance at anaesthesia in connection with emergency treatment (Item [25200](#))

Item 25200 provides for assistance at anaesthesia where the patient is in imminent danger of death.

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

T10.8.3 Assistance in the administration of elective anaesthesia (Item [25205](#))

T10.8.4 A separate benefit is payable under Item [25205](#) for the services of an assistant anaesthetist in connection with elective anaesthesia in the circumstances outlined in the item descriptor. This benefit is only payable in respect of one assistant anaesthetist who must not be the surgeon or assistant surgeon.

T10.8.5 For the purposes of Item [25205](#), 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.

T10.9 Perfusion Services (Items [22055-22075](#))

T10.9.1 Perfusion services covered by items [22055-22075](#) have been included in the RVG format.

T10.9.2 The “Time” component for item [22060](#) is defined as beginning with the commencement of anaesthesia and finishing with the closure of the chest.

T10.9.3 Medicare benefits are not payable for perfusion unless the perfusion is performed by a medical practitioner other than the medical practitioner who renders the associated medical service in Group [T8](#) or the medical practitioner who administers the anaesthesia listed in the RVG in Group [T10](#). The service must be performed by a medical practitioner in order to attract Medicare benefits. The “on behalf of” provisions do not apply.

T10.9.4 Medicare benefit is payable where the perfusionist provides a clinically necessary service/s from Group [T10](#), Subgroup 19 in addition to the perfusion service.

T10.10 Anaesthesia as a therapeutic procedure (Item [21965](#))

T10.10.1 Claims under this item should be submitted to Medicare for approval of benefits and should contain full clinical details of the service. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked ‘Medical-in Confidence’. (See note 8.7 of the General Explanatory Notes of the 1 November 2002 Medicare Benefits Schedule.)

T10.11 Discontinued Surgery (Item [21990](#))

T10.11.1 Claims for benefits under Item [21990](#) should be submitted to Medicare for approval of benefits and should include full details of the circumstances of the operation, including details of the surgery which had been proposed and the reasons for the operation being discontinued.

T10.12 Anaesthesia in connection with a procedure not identified as attracting a Medicare benefit for anaesthesia (Item [21997](#))

T10.12.1 Payment of benefit for Item [21997](#) is not restricted to the service being performed in connection with a surgical service in Group [T8](#). Item [21997](#) may be performed with any item in the Medicare Benefits Schedule that has not been identified as attracting a Medicare benefit for anaesthesia (including attendances) in circumstances where anaesthesia is considered clinically necessary. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked ‘Medical-in Confidence’. (See note [8.6](#) of the General Explanatory Notes of the 1 November 2002 Medicare Benefits Schedule.)

T10.13 Anaesthesia in connection with a dental service (Items [22900](#) and [22905](#))

T10.13.1 Items [22900](#) and [22905](#) cover the administration of anaesthesia in connection with a dental service that is not a service covered by an item in the Medicare Benefits Schedule i.e removal of teeth and restorative dental work. Therefore, the requirement that anaesthesia be performed in association with an “eligible” service (as defined in point [T10.2](#)) does not apply to dental anaesthesia items [22900](#) and [22905](#).

T10.14 Anaesthesia in connection with cleft lip and cleft palate repair (Items [20102](#) and [20172](#))

T10.14.1 Anaesthesia associated with cleft lip and cleft palate repair is covered in Subgroup 1 of the RVG Schedule, under items [20102](#) and [20172](#).

T10.15 Anaesthesia in connection with an Oral and Maxillofacial service (Category 4 of the Medicare Schedule) Benefits

T10.15.1 Benefit for anaesthesia provided by a medical practitioner in association with an Oral and Maxillofacial service (Category 4 of the Medicare Benefits Schedule) is derived using the RVG (see point OC.4 in Category 4 of the Medicare Benefits Schedule). Benefit for anaesthesia for oral and maxillofacial services should be claimed under the appropriate RVG item from Subgroup 1 or 2.

T10.16 Peri-operative blocks for post operative pain (Items [22030](#) to [22050](#))

T10.16.1 Benefits are only payable for peri-operative nerve blocks performed for the management of post-operative pain that are specifically catered for under items [22030](#) to [22050](#).

T10.17 Anaesthesia in connection with extensive surgery on facial bones([20192](#))

The term “extensive” in relation to this item is defined as major facial bone surgery or reconstruction including major resection or osteotomies or osteectomies of mandibles and/or maxillae, surgery for prognathism or surgery for Le Fort II or III fractures.

T10.18 Introduction of a Narcotic (Item [22030](#))

T10.18.1 Benefits are attracted for this procedure irrespective of the stage of the operation at which the narcotic is introduced.

T10.19 Epidural Injection for Control of Post-operative Pain (Item [22035](#))

T10.19.1 This item provides benefit for the epidural injection of a local anaesthetic in the caudal, lumbar or thoracic region administered towards the end of an operation for the purposes of controlling pain in the post-operative period.

T10.20 Regional or Field Nerve Blocks for Post-operative Pain (Items [22040](#) - [22050](#))

T10.20.1 Benefits are payable under Items [22040](#) to [22050](#) in addition to the general anaesthesia for the related procedure.

T10.21 Anaesthesia for radical procedures on the chest wall (Item [20474](#))

T10.21.1 Radical procedures on the chest wall referred to in item [20474](#) would include procedures such as pectus excavatum.

T10.22 Anaesthesia for extensive spine or spinal cord procedures (Item [20670](#))

T10.22.1 This item covers major spinal surgery involving multiple levels of the spinal cord and spinal fusion where performed. Procedures covered under this item would include the Harrington Rod technique. Surgery on individual spinal levels would be covered under items [20600](#), [20620](#) and [20630](#).

T10.23 Anaesthesia for femoral artery embolectomy (Item [21274](#))

T10.23.1 Item [21274](#) covers anaesthesia for femoral artery embolectomy. Grafts involving intra-abdominal vessels would be covered under item [20880](#).

T10.24 Anaesthesia for cardiac catheterisation (Item [21941](#))

T10.24.1 Item [21941](#) does not include either central vein catheterisation or insertion of right heart balloon catheter. Anaesthesia for these procedures is covered under item [21943](#).

T10.25 Anaesthesia for 2 dimensional real time transoesophageal echocardiography (Item [21936](#))

T10.25.1 Benefits are payable for anaesthesia in connection with 2 dimensional real time transoesophageal echocardiography, (including intra-operative echocardiography) which includes doppler techniques, real time colour flow mapping and recording onto video tape or digital medium.

T10.26 Anaesthesia for services on the upper and lower abdomen (subgroups 6 and7)

T10.26.1 Establishing whether an RVG anaesthetic item pertains to the upper or lower abdomen, depends on whether the majority of the associated surgery was performed in the region above or below the umbilicus.

Some examples of upper abdomen would be: -

- laparoscopy on upper abdominal viscera;
- laparoscopy with operative focus superior to the umbilical port;
- surgery to the liver, gallbladder and ducts, stomach, pancreas, small bowel to DJ flexure;
- the kidneys in their normal location (as opposed to pelvic kidney); or
- spleen or bowel (where it involves a diaphragmatic hernia or adhesions to gallbladder bed).

Some examples of lower abdomen would be: -

- abdominal wall below the umbilicus;
- laparoscopy on lower abdominal viscera;
- laparoscopy with operative focus inferior to the umbilical port;
- surgery on the colon;
- surgery on the appendix; or
- surgery associated with the female reproductive system.

MISCELLANEOUS		HYPERBARIC OXYGEN THERAPY	
GROUP T1 - MISCELLANEOUS THERAPEUTIC PROCEDURES			
SUBGROUP 1 - HYPERBARIC OXYGEN THERAPY			
13020	<p>HYPERBARIC OXYGEN THERAPY, for treatment of decompression illness, gas gangrene, air or gas embolism; diabetic wounds including diabetic gangrene and diabetic foot ulcers; necrotising soft tissue infections including necrotising fasciitis or Fournier's gangrene; or for the prevention and treatment of osteoradionecrosis, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber of between 1 hour 30 minutes and 3 hours, including any associated attendance (See para T1.1 of explanatory notes to this Category)</p>	Fee: \$209.80	Benefit: 75% = \$157.35 85% = \$178.35
13025	<p>HYPERBARIC OXYGEN THERAPY for treatment of decompression illness, air or gas embolism, performed in a comprehensive hyperbaric medicine facility, under the supervision of a medical practitioner qualified in hyperbaric medicine, for a period in the hyperbaric chamber greater than 3 hours, including any associated attendance - per hour (or part of an hour) (See para T1.1 of explanatory notes to this Category)</p>	Fee: \$93.85	Benefit: 75% = \$70.40 85% = \$79.80
13030	<p>HYPERBARIC OXYGEN THERAPY performed in a comprehensive hyperbaric medicine facility where the medical practitioner is pressurised in the hyperbaric chamber for the purpose of providing continuous life saving emergency treatment, including any associated attendance - per hour (or part of an hour) (See para T1.1 of explanatory notes to this Category)</p>	Fee: \$132.55	Benefit: 75% = \$99.45 85% = \$112.70
SUBGROUP 2 - DIALYSIS			
13100	<p>SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist exceeds 45 minutes in 1 day (See para T1.2 of explanatory notes to this Category)</p>	Fee: \$110.80	Benefit: 75% = \$83.10 85% = \$94.20
13103	<p>SUPERVISION IN HOSPITAL by a medical specialist of haemodialysis, haemofiltration, haemoperfusion or peritoneal dialysis, including all professional attendances, where the total attendance time on the patient by the supervising medical specialist does not exceed 45 minutes in 1 day (See para T1.2 of explanatory notes to this Category)</p>	Fee: \$57.70	Benefit: 75% = \$43.30 85% = \$49.05
13106	<p>DECLOTTING OF AN ARTERIOVENOUS SHUNT</p>	Fee: \$98.45	Benefit: 75% = \$73.85 85% = \$83.70
13109	<p>INDWELLING PERITONEAL CATHETER (Tenckhoff or similar) FOR DIALYSIS INSERTION AND FIXATION OF (Anaes.)</p>	Fee: \$184.65	Benefit: 75% = \$138.50 85% = \$157.00
13110	<p>TENCKHOFF PERITONEAL DIALYSIS CATHETER, removal of (including catheter cuffs) (Anaes.)</p>	Fee: \$185.20	Benefit: 75% = \$138.90 85% = \$157.45
13112	<p>PERITONEAL DIALYSIS, establishment of, by abdominal puncture and insertion of temporary catheter (including associated consultation) (Anaes.)</p>	Fee: \$110.80	Benefit: 75% = \$83.10 85% = \$94.20
SUBGROUP 3 - ASSISTED REPRODUCTIVE SERVICES			
13200	<p>ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures) involving the use of drugs to induce superovulation, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination or transfer of frozen embryos or donated embryos or ova or a service to which item 13203, 13206 or 13218 applies - being services rendered during 1 treatment cycle, if the duration of the treatment cycle is at least 9 days (See para T1.3 of explanatory notes to this Category)</p>	Fee: \$1,620.95	Benefit: 75% = \$1,215.75 85% = \$1,563.85
13203	<p>OVULATION MONITORING SERVICES, for superovulated treatment cycles of less than 9 days duration and artificial insemination - including quantitative estimation of hormones and ultrasound examinations, being services rendered during 1 treatment cycle but excluding a service to which item 13200, 13206, 13212, 13215 or 13218 applies (See para T1.3 of explanatory notes to this Category)</p>	Fee: \$405.25	Benefit: 75% = \$303.95 85% = \$348.15

MISCELLANEOUS	PAEDIATRIC & NEONATAL
13206	<p>ASSISTED REPRODUCTIVE SERVICES (such as in vitro fertilisation, gamete intrafallopian transfer or similar procedures), using unstimulated ovulation or ovulation stimulated only by clomiphene citrate, and including quantitative estimation of hormones, ultrasound examinations, all treatment counselling and embryology laboratory services but excluding artificial insemination, frozen embryo transfer or donated embryos or ova or treatment involving the use of drugs to induce superovulation being services rendered during 1 treatment cycle but only if rendered in conjunction with a service to which item 13212 applies (See para T1.3 of explanatory notes to this Category)</p> <p>Fee: \$694.65 Benefit: 75% = \$521.00 85% = \$637.55</p>
13209	<p>PLANNING and MANAGEMENT of a referred patient by a specialist for the purpose of treatment by assisted reproductive technologies including in vitro fertilisation, gamete intrafallopian transfer and similar procedures, or for artificial insemination payable once only during 1 treatment cycle (See para T1.3 of explanatory notes to this Category)</p> <p>Fee: \$69.35 Benefit: 75% = \$52.05 85% = \$58.95</p>
13212	<p>OOCYTE RETRIEVAL by any means including laparoscopy or ultrasoundguided ova flushing, for the purposes of assisted reproductive technologies including in vitro fertilisation, gamete intra-fallopian transfer or similar procedures - only if rendered in conjunction with a service to which item 13200 or 13206 applies (Anaes.) (See para T1.3 of explanatory notes to this Category)</p> <p>Fee: \$295.25 Benefit: 75% = \$221.45 85% = \$251.00</p>
13215	<p>TRANSFER of EMBRYOS or both ova and sperm to the female reproductive system, by any means but excluding artificial insemination or the transfer of frozen or donated embryos - only if rendered in conjunction with a service to which item 13200 or 13206 applies, being services rendered in 1 treatment cycle (Anaes.) (See para T1.3 of explanatory notes to this Category)</p> <p>Fee: \$92.65 Benefit: 75% = \$69.50 85% = \$78.80</p>
13218	<p>PREPARATION AND TRANSFER of frozen or donated embryos or both ova and sperm, to the female reproductive system, by any means and including quantitative estimation of hormones and all treatment counselling but excluding artificial insemination services rendered in 1 treatment cycle and excluding a service to which item 13200, 13203, 13206, 13212 or 13215 applies (Anaes.) (See para T1.3 of explanatory notes to this Category)</p> <p>Fee: \$694.65 Benefit: 75% = \$521.00 85% = \$637.55</p>
13221	<p>PREPARATION OF SEMEN for the purposes of assisted reproductive technologies or for artificial insemination (See para T1.3 of explanatory notes to this Category)</p> <p>Fee: \$42.30 Benefit: 75% = \$31.75 85% = \$36.00</p>
13290	<p>SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required</p> <p>Fee: \$165.65 Benefit: 75% = \$124.25 85% = \$140.85</p>
13292	<p>SEMEN, collection of, from a patient with spinal injuries or medically induced impotence, for the purposes of analysis, storage or assisted reproduction, by a medical practitioner using a vibrator or electro-ejaculation device including catheterisation and drainage of bladder where required, under general anaesthetic, in a hospital or approved day-hospital facility (Anaes.)</p> <p>Fee: \$331.30 Benefit: 75% = \$248.50 85% = \$281.65</p>
SUBGROUP 4 - PAEDIATRIC & NEONATAL	
13300	<p>UMBILICAL OR SCALP VEIN CATHETERISATION in a NEONATE with or without infusion; or cannulation of a vein in a neonate</p> <p>Fee: \$46.20 Benefit: 75% = \$34.65 85% = \$39.30</p>
13303	<p>UMBILICAL ARTERY CATHETERISATION with or without infusion</p> <p>Fee: \$68.45 Benefit: 75% = \$51.35 85% = \$58.20</p>
13306	<p>BLOOD TRANSFUSION with venesection and complete replacement of blood, including collection from donor</p> <p>Fee: \$270.85 Benefit: 75% = \$203.15 85% = \$230.25</p>
13309	<p>BLOOD TRANSFUSION with venesection and complete replacement of blood, using blood already collected</p> <p>Fee: \$230.95 Benefit: 75% = \$173.25 85% = \$196.35</p>
13312	<p>BLOOD for pathology test, collection of, BY FEMORAL OR EXTERNAL JUGULAR VEIN PUNCTURE IN INFANTS</p> <p>Fee: \$23.00 Benefit: 75% = \$17.25 85% = \$19.55</p>
13318	<p>CENTRAL VEIN CATHETERISATION (via jugular or subclavian vein) - by open exposure in a person under 12 years of age (Anaes.)</p> <p>Fee: \$184.45 Benefit: 75% = \$138.35 85% = \$156.80</p>

MISCELLANEOUS		CARDIOVASCULAR
13319	CENTRAL VEIN CATHETERISATION in a neonate via peripheral vein (Anaes.) Fee: \$184.45 Benefit: 75% = \$138.35 85% = \$156.80	
SUBGROUP 5 - CARDIOVASCULAR		
13400	RESTORATION OF CARDIAC RHYTHM by electrical stimulation (cardioversion), other than in the course of cardiac surgery (Anaes.) Fee: \$78.50 Benefit: 75% = \$58.90 85% = \$66.75	
SUBGROUP 6 - GASTROENTEROLOGY		
13500	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant IN THE ABSENCE OF GASTROINTESTINAL HAEMORRHAGE Fee: \$146.20 Benefit: 75% = \$109.65 85% = \$124.30	
13503	GASTRIC HYPOTHERMIA by closed circuit circulation of refrigerant FOR UPPER GASTROINTESTINAL HAEMORRHAGE Fee: \$292.45 Benefit: 75% = \$219.35 85% = \$248.60	
13506	GASTRO-OESOPHAGEAL balloon intubation, Minnesota, Sengstaken-Blakemore or similar, for control of bleeding from gastric oesophageal varices Fee: \$149.55 Benefit: 75% = \$112.20 85% = \$127.15	
SUBGROUP 8 - HAEMATOLOGY		
13700	HARVESTING OF HOMOLOGOUS (including allogeneic) or AUTOLOGOUS bone marrow for the purpose of transplantation (Anaes.) Fee: \$270.25 Benefit: 75% = \$202.70 85% = \$229.75	
13703	ADMINISTRATION OF BLOOD, including collection from donor Fee: \$96.85 Benefit: 75% = \$72.65 85% = \$82.35	
13706	ADMINISTRATION OF BLOOD or bone marrow already collected (<i>See para T1.4 of explanatory notes to this Category</i>) Fee: \$67.65 Benefit: 75% = \$50.75 85% = \$57.55	
13709	COLLECTION OF BLOOD for autologous transfusion or when homologous blood is required for immediate transfusion in emergency situation (<i>See para T1.5 of explanatory notes to this Category</i>) Fee: \$39.25 Benefit: 75% = \$29.45 85% = \$33.40	
13750	THERAPEUTIC HAEMAPHERESIS for the removal of plasma or cellular (or both) elements of blood, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies, if performed; continuous monitoring of vital signs, fluid balance, blood volume and other parameters with continuous registered nurse attendance under the supervision of a consultant physician, not being a service associated with a service to which item 13755 applies -payable once per day Fee: \$110.80 Benefit: 75% = \$83.10 85% = \$94.20	
13755	DONOR HAEMAPHERESIS for the collection of blood products for transfusion, utilising continuous or intermittent flow techniques; including morphological tests for cell counts and viability studies; continuous monitoring of vital signs, fluid balance, blood volume and other parameters; with continuous registered nurse attendance under the supervision of a consultant physician; not being a service associated with a service to which item 13750 applies - payable once per day Fee: \$110.80 Benefit: 75% = \$83.10 85% = \$94.20	
13757	THERAPEUTIC VENESECTION for the management of haemochromatosis, polycythemia vera or porphyria cutanea tarda Fee: \$59.15 Benefit: 75% = \$44.40 85% = \$50.30	

MISCELLANEOUS	INTENSIVE CARE
13760	<p>IN VITRO PROCESSING (and cryopreservation) of bone marrow or peripheral blood for autologous stem cell transplantation as an adjunct to high dose chemotherapy for:</p> <ul style="list-style-type: none"> . chemosensitive intermediate or high grade non-Hodgkin's lymphoma at high risk of relapse following first line chemotherapy; or . Hodgkin's disease which has relapsed following, or is refractory to, chemotherapy; or . acute myelogenous leukaemia in first remission, where suitable genotypically matched sibling donor is not available for allogenic bone marrow transplant; or . multiple myeloma in remission (complete or partial) following standard dose chemotherapy; or . small round cell sarcomas; or . primitive neuroectodermal tumour; or . germ cell tumours which have relapsed following, or are refractory to, chemotherapy; . germ cell tumours which have had an incomplete response to first line therapy. <p>- performed under the supervision of a consultant physician - each day.</p> <p>Fee: \$618.35 Benefit: 75% = \$463.80 85% = \$561.25</p>
SUBGROUP 9 - PROCEDURES ASSOCIATED WITH INTENSIVE CARE AND CARDIOPULMONARY SUPPORT	
13815	<p>CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure not being a service to which item 13318 applies (Anaes.)</p> <p>Fee: \$69.10 Benefit: 75% = \$51.85 85% = \$58.75</p>
13818	<p>RIGHT HEART BALLOON CATHETER, insertion of, including pulmonary wedge pressure and cardiac output measurement (Anaes.) (See para T1.7 of explanatory notes to this Category)</p> <p>Fee: \$92.20 Benefit: 75% = \$69.15 85% = \$78.40</p>
13830	<p>INTRACRANIAL PRESSURE, monitoring of, by intraventricular or subdural catheter, subarachnoid bolt or similar, by a specialist or consultant physician - each day</p> <p>Fee: \$61.10 Benefit: 75% = \$45.85 85% = \$51.95</p>
13839	<p>ARTERIAL PUNCTURE and collection of blood for diagnostic purposes</p> <p>Fee: \$18.65 Benefit: 75% = \$14.00 85% = \$15.90</p>
13842	<p>INTRAARTERIAL CANNULISATION for the purpose of taking multiple arterial blood samples for blood gas analysis (See para T1.7 of explanatory notes to this Category)</p> <p>Fee: \$56.15 Benefit: 75% = \$42.15 85% = \$47.75</p>
13845	<p>COUNTERPULSATION BY INTRAAORTIC BALLOON management on the first day, including percutaneous insertion, initial and subsequent consultations and monitoring of parameters (Anaes.)</p> <p>Fee: \$438.60 Benefit: 75% = \$328.95 85% = \$381.50</p>
13848	<p>COUNTERPULSATION BY INTRAAORTIC BALLOON management on each day subsequent to the first, including associated consultations and monitoring of parameters</p> <p>Fee: \$106.25 Benefit: 75% = \$79.70 85% = \$90.35</p>
13851	<p>CIRCULATORY SUPPORT DEVICE, management of, on first day</p> <p>Fee: \$400.25 Benefit: 75% = \$300.20 85% = \$343.15</p>
13854	<p>CIRCULATORY SUPPORT DEVICE, management of, on each day subsequent to the first</p> <p>Fee: \$93.05 Benefit: 75% = \$69.80 85% = \$79.10</p>
13857	<p>MECHANICAL VENTILATION, initiation of (other than initiation of ventilation in the context of an anaesthetic for surgery), outside of an Intensive Care Unit, where subsequent management of ventilatory support is undertaken in an Intensive Care Unit (See para T1.7 of explanatory notes to this Category)</p> <p>Fee: \$118.70 Benefit: 75% = \$89.05 85% = \$100.90</p>
SUBGROUP 10 - MANAGEMENT AND PROCEDURES UNDERTAKEN IN AN INTENSIVE CARE UNIT	
13870	<p style="text-align: center;"><i>(Note: See para T1.7 of Explanatory Notes to this Category for definition of an Intensive Care Unit)</i></p> <p>MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including initial and subsequent attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling - management on the first day (See para T1.8 of explanatory notes to this Category)</p> <p>Fee: \$247.35 Benefit: 75% = \$185.55 85% = \$210.25</p>

MISCELLANEOUS		CHEMOTHERAPEUTIC	
13873	MANAGEMENT of a patient in an Intensive Care Unit by a specialist or consultant physician - including all attendances, electrocardiographic monitoring, arterial sampling, bladder catheterisation and blood sampling - management on each day subsequent to the first day (See para T1.8 of explanatory notes to this Category)	Fee: \$184.20	Benefit: 75% = \$138.15 85% = \$156.60
13876	CENTRAL VENOUS PRESSURE, pulmonary arterial pressure, systemic arterial pressure or cardiac intracavity pressure, continuous monitoring by indwelling catheter by a specialist or consultant physician in an Intensive Care Unit - each day of monitoring for each type of pressure up to a maximum of 4 pressures (See para T1.8 of explanatory notes to this Category)	Fee: \$56.15	Benefit: 75% = \$42.15 85% = \$47.75
13879	MECHANICAL VENTILATION, initiation of, by a specialist or consultant physician, in an Intensive Care Unit, including subsequent management of ventilatory support on the first day	Fee: \$179.50	Benefit: 75% = \$134.65 85% = \$152.60
13882	VENTILATORY SUPPORT in an Intensive Care Unit, management of, by a specialist or consultant physician - not being a service to which item 13879 applies - each day	Fee: \$61.10	Benefit: 75% = \$45.85 85% = \$51.95
13885	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on the first day in an Intensive Care Unit	Fee: \$110.50	Benefit: 75% = \$82.90 85% = \$93.95
13888	CONTINUOUS ARTERIO VENOUS OR VENO VENOUS HAEMOFILTRATION, management by a specialist or consultant physician - on each day subsequent to the first day in an Intensive Care Unit	Fee: \$57.55	Benefit: 75% = \$43.20 85% = \$48.95
SUBGROUP 11 - CHEMOTHERAPEUTIC PROCEDURES			
13915	CYTOTOXIC CHEMOTHERAPY, administration of, either by intravenous push technique (directly into a vein, or a butterfly needle, or the side-arm of an infusion) or by intravenous infusion of not more than 1 hours duration - payable once only on the same day, not being a service associated with photodynamic therapy with verteporfin	Fee: \$52.75	Benefit: 75% = \$39.60 85% = \$44.85
13918	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day	Fee: \$79.35	Benefit: 75% = \$59.55 85% = \$67.45
13921	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - for the first day of treatment	Fee: \$89.80	Benefit: 75% = \$67.35 85% = \$76.35
13924	CYTOTOXIC CHEMOTHERAPY, administration of, by intravenous infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode	Fee: \$52.95	Benefit: 75% = \$39.75 85% = \$45.05
13927	CYTOTOXIC CHEMOTHERAPY, administration of, either by intra-arterial push technique (directly into an artery, a butterfly needle or the side-arm of an infusion) or by intra-arterial infusion of not more than 1 hours duration - payable once only on the same day	Fee: \$68.45	Benefit: 75% = \$51.35 85% = \$58.20
13930	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 1 hours duration but not more than 6 hours duration - payable once only on the same day	Fee: \$95.50	Benefit: 75% = \$71.65 85% = \$81.20
13933	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - for the first day of treatment	Fee: \$105.95	Benefit: 75% = \$79.50 85% = \$90.10
13936	CYTOTOXIC CHEMOTHERAPY, administration of, by intra-arterial infusion of more than 6 hours duration - on each day subsequent to the first in the same continuous treatment episode	Fee: \$69.00	Benefit: 75% = \$51.75 85% = \$58.65
13939	IMPLANTED PUMP OR RESERVOIR, loading of, with a cytotoxic agent or agents, not being a service associated with a service to which item 13915 , 13918 , 13921 , 13924 , 13927 , 13930 , 13933 , 13936 or 13945 applies (See para T1.9 of explanatory notes to this Category)	Fee: \$79.35	Benefit: 75% = \$59.55 85% = \$67.45

MISCELLANEOUS		DERMATOLOGY	
13942	AMBULATORY DRUG DELIVERY DEVICE, loading of, with a cytotoxic agent or agents for the infusion of the agent or agents via the intravenous, intra-arterial or spinal routes, not being a service associated with a service to which item 13915 , 13918 , 13921 , 13924 , 13927 , 13930 , 13933 , 13936 or 13945 applies (See para T1.9 of explanatory notes to this Category)	Fee: \$52.95	Benefit: 75% = \$39.75 85% = \$45.05
13945	LONG-TERM IMPLANTED DRUG DELIVERY DEVICE FOR CYTOTOXIC CHEMOTHERAPY, accessing of	Fee: \$42.60	Benefit: 75% = \$31.95 85% = \$36.25
13948	CYTOTOXIC AGENT, instillation of, into a body cavity	Fee: \$52.95	Benefit: 75% = \$39.75 85% = \$45.05
SUBGROUP 12 - DERMATOLOGY			
14050	PUVA THERAPY or UVB THERAPY administered in whole body cabinet, not being a service associated with a service to which item 14053 applies including associated consultations other than an initial consultation (See para T1.10 of explanatory notes to this Category)	Fee: \$42.80	Benefit: 75% = \$32.10 85% = \$36.40
14053	PUVA THERAPY or UVB THERAPY administered to localised body areas in hand and foot cabinet not being a service associated with a service to which item 14050 applies including associated consultations other than an initial consultation (See para T1.10 of explanatory notes to this Category)	Fee: \$42.80	Benefit: 75% = \$32.10 85% = \$36.40
14100	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - session of at least 30 minutes duration (Anaes.)	Fee: \$123.65	Benefit: 75% = \$92.75 85% = \$105.15
14103	LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - session of at least 60 minutes duration (Anaes.)	Fee: \$151.85	Benefit: 75% = \$113.90 85% = \$129.10
14106	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment up to 50cm ² (Anaes.) (See para T1.11 of explanatory notes to this Category)	Fee: \$123.65	Benefit: 75% = \$92.75 85% = \$105.15
14109	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 50cm ² and up to 100cm ² (Anaes.) (See para T1.11 of explanatory notes to this Category)	Fee: \$151.85	Benefit: 75% = \$113.90 85% = \$129.10
14112	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 100cm ² and up to 150cm ² (Anaes.) (See para T1.11 of explanatory notes to this Category)	Fee: \$179.85	Benefit: 75% = \$134.90 85% = \$152.90
14115	LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 150cm ² and up to 250cm ² (Anaes.) (See para T1.11 of explanatory notes to this Category)	Fee: \$207.90	Benefit: 75% = \$155.95 85% = \$176.75

MISCELLANEOUS	OTHER
14118	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation, up to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - area of treatment more than 250cm² (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$264.15 Benefit: 75% = \$198.15 85% = \$224.55</p>
14120	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation - session of at least 30 minutes duration - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$123.65 Benefit: 75% = \$92.75 85% = \$105.15</p>
14122	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-600nm in the treatment of severely disfiguring vascular lesions of the head or neck where abnormality is visible from 4 metres, including any associated consultation, session of at least 60 minutes duration - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$151.85 Benefit: 75% = \$113.90 85% = \$129.10</p>
14124	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment up to 50cm² - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$123.65 Benefit: 75% = \$92.75 85% = \$105.15</p>
14126	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than 50cm² and up to 100cm² - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$151.85 Benefit: 75% = \$113.90 85% = \$129.10</p>
14128	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than 100cm² and up to 150cm² - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$179.85 Benefit: 75% = \$134.90 85% = \$152.90</p>
14130	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than 150cm² and up to 250cm² - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$207.90 Benefit: 75% = \$155.95 85% = \$176.75</p>
14132	<p>LASER PHOTOCOAGULATION using laser light within the wave length of 510-1064nm in the treatment of port wine stains, haemangiomas, cafe-au-lait macules and naevi of Ota, other than melanocytic naevi (common moles), including any associated consultation - area of treatment more than 250cm² - <i>where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period</i> (Anaes.) (See para T1.11 of explanatory notes to this Category)</p> <p>Fee: \$264.15 Benefit: 75% = \$198.15 85% = \$224.55</p>
SUBGROUP 13 - OTHER THERAPEUTIC PROCEDURES	
14200	<p>GASTRIC LAVAGE in the treatment of ingested poison</p> <p>Fee: \$48.55 Benefit: 75% = \$36.45 85% = \$41.30</p>
14203	<p>HORMONE OR LIVING TISSUE IMPLANTATION, by direct implantation involving incision and suture (Anaes.)</p> <p>Fee: \$41.45 Benefit: 75% = \$31.10 85% = \$35.25</p>
14206	<p>HORMONE OR LIVING TISSUE IMPLANTATION by cannula</p> <p>Fee: \$28.90 Benefit: 75% = \$21.70 85% = \$24.60</p>

MISCELLANEOUS		OTHER
14209	INTRAARTERIAL INFUSION or retrograde intravenous perfusion of a sympatholytic agent Fee: \$71.95 Benefit: 75% = \$54.00 85% = \$61.20	
14212	INTUSSUSCEPTION, management of fluid or gas reduction for (Anaes.) Fee: \$150.25 Benefit: 75% = \$112.70 85% = \$127.75	
14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid Fee: \$79.35 Benefit: 75% = \$59.55 85% = \$67.45	
14218	IMPLANTED PUMP OR RESERVOIR, LOADING OF, with a therapeutic agent or agents, for infusion to the subarachnoid or epidural space Fee: \$79.35 Benefit: 75% = \$59.55 85% = \$67.45	
14221	LONG-TERM IMPLANTED DEVICE FOR DELIVERY OF THERAPEUTIC AGENTS, accessing of, not being a service associated with a service to which item 13945 applies Fee: \$42.60 Benefit: 75% = \$31.95 85% = \$36.25	
14224	ELECTROCONVULSIVE THERAPY, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation (Anaes.) Fee: \$57.00 Benefit: 75% = \$42.75 85% = \$48.45	

RADIATION ONCOLOGY		SUPERFICIAL	
GROUP T2 - RADIATION ONCOLOGY			
SUBGROUP 1 - SUPERFICIAL			
	<i>(Benefits for administration of general anaesthetic for radiotherapy are payable under item 17965)</i>		
	RADIOTHERAPY, SUPERFICIAL (including treatment with xrays, radium rays or other radioactive substances), not being a service to which another item in this Group applies each attendance at which fractionated treatment is given - 1 field		
15000	Fee: \$34.55	Benefit: 75% = \$25.95	85% = \$29.40
15003	- 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15000 plus for each field in excess of 1, an amount of \$13.85		
	RADIOTHERAPY, SUPERFICIAL, attendance at which single dose technique is applied - 1 field		
15006	Fee: \$76.55	Benefit: 75% = \$57.45	85% = \$65.10
15009	- 2 or more fields up to a maximum of 5 additional fields Derived Fee: The fee for item 15006 plus for each field in excess of 1, an amount of \$15.05		
	RADIOTHERAPY, SUPERFICIAL each attendance at which treatment is given to an eye		
15012	Fee: \$43.30	Benefit: 75% = \$32.50	85% = \$36.85
SUBGROUP 2 - ORTHOVOLTAGE			
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 3 or more treatments per week - 1 field		
15100	Fee: \$38.70	Benefit: 75% = \$29.05	85% = \$32.90
15103	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived Fee: The fee for item 15100 plus for each field in excess of 1, an amount of \$15.25		
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE each attendance at which fractionated treatment is given at 2 treatments per week or less frequently - 1 field		
15106	Fee: \$45.65	Benefit: 75% = \$34.25	85% = \$38.85
15109	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived Fee: The fee for item 15106 plus for each field in excess of 1, an amount of \$18.40		
	RADIOTHERAPY, DEEP OR ORTHOVOLTAGE attendance at which single dose technique is applied 1 field		
15112	Fee: \$97.45	Benefit: 75% = \$73.10	85% = \$82.85
15115	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived Fee: The fee for item 15112 plus for each field in excess of 1, an amount of \$38.35		
SUBGROUP 3 - MEGAVOLTAGE			
	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field		
15203	Fee: \$48.40	Benefit: 75% = \$36.30	85% = \$41.15
15204	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived Fee: The fee for item 15203 plus for each field in excess of 1, an amount of \$30.75		
	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10 MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field		
15207	Fee: \$48.40	Benefit: 75% = \$36.30	85% = \$41.15
15208	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived Fee: The fee for item 15207 plus for each field in excess of 1, an amount of \$30.75		

RADIATION ONCOLOGY		BRACHYTHERAPY	
15211	RADIATION ONCOLOGY TREATMENT, using cobalt unit or caesium teletherapy unit each attendance at which treatment is given - 1 field Fee: \$44.35	Benefit: 75% = \$33.30	85% = \$37.70
15214	- 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) Derived Fee: The fee for item 15211 plus for each field in excess of 1, an amount of \$25.85		
SUBGROUP 4 - BRACHYTHERAPY			
15303	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) Fee: \$289.45	Benefit: 75% = \$217.10	85% = \$246.05
15304	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) Fee: \$289.45	Benefit: 75% = \$217.10	85% = \$246.05
15307	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) Fee: \$548.80	Benefit: 75% = \$411.60	85% = \$491.70
15308	INTRAUTERINE TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) Fee: \$548.80	Benefit: 75% = \$411.60	85% = \$491.70
15311	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) Fee: \$270.20	Benefit: 75% = \$202.65	85% = \$229.70
15312	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) Fee: \$268.25	Benefit: 75% = \$201.20	85% = \$228.05
15315	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) Fee: \$530.45	Benefit: 75% = \$397.85	85% = \$473.35
15316	INTRAVAGINAL TREATMENT ALONE using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) Fee: \$530.45	Benefit: 75% = \$397.85	85% = \$473.35
15319	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using manual afterloading techniques (Anaes.) Fee: \$329.15	Benefit: 75% = \$246.90	85% = \$279.80
15320	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life greater than 115 days using automatic afterloading techniques (Anaes.) Fee: \$329.15	Benefit: 75% = \$246.90	85% = \$279.80
15323	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using manual afterloading techniques (Anaes.) Fee: \$585.35	Benefit: 75% = \$439.05	85% = \$528.25
15324	COMBINED INTRAUTERINE AND INTRAVAGINAL TREATMENT using radioactive sealed sources having a half-life of less than 115 days including iodine, gold, iridium or tantalum using automatic afterloading techniques (Anaes.) Fee: \$585.35	Benefit: 75% = \$439.05	85% = \$528.25
15327	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using manual afterloading techniques (Anaes.) Fee: \$636.85	Benefit: 75% = \$477.65	85% = \$579.75
15328	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a region, under general anaesthesia, or epidural or spinal (intrathecal) nerve block, requiring surgical exposure and using automatic afterloading techniques (Anaes.) Fee: \$636.85	Benefit: 75% = \$477.65	85% = \$579.75

RADIATION ONCOLOGY		COMPUTERISED PLANNING
15331	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using manual afterloading techniques (Anaes.) Fee: \$604.70 Benefit: 75% = \$453.55 85% = \$547.60	
15332	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site (including the tongue, mouth, salivary gland, axilla, subcutaneous sites), where the volume treated involves multiple planes but does not require surgical exposure and using automatic afterloading techniques (Anaes.) Fee: \$604.70 Benefit: 75% = \$453.55 85% = \$547.60	
15335	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using manual afterloading techniques (Anaes.) Fee: \$548.80 Benefit: 75% = \$411.60 85% = \$491.70	
15336	IMPLANTATION OF A SEALED RADIOACTIVE SOURCE (having a half-life of less than 115 days including iodine, gold, iridium or tantalum) to a site where the volume treated involves only a single plane but does not require surgical exposure and using automatic afterloading techniques (Anaes.) Fee: \$548.80 Benefit: 75% = \$411.60 85% = \$491.70	
15338	PROSTATE, radioactive seed implantation of, radiation oncology component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1, T2A or T2B, with a Gleason score of less than or equal to 6 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed at an approved site in association with a urologist. (See para T2.3 of explanatory notes to this Category) Fee: \$758.50 Benefit: 75% = \$568.90 85% = \$701.40	
15339	REMOVAL OF A SEALED RADIOACTIVE SOURCE under general anaesthesia, or under epidural or spinal nerve block (Anaes.) Fee: \$61.75 Benefit: 75% = \$46.35 85% = \$52.50	
15342	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of greater than 115 days, to treat intracavity, intraoral or intranasal site Fee: \$154.30 Benefit: 75% = \$115.75 85% = \$131.20	
15345	CONSTRUCTION AND APPLICATION OF A RADIOACTIVE MOULD using a sealed source having a half-life of less than 115 days including iodine, gold, iridium or tantalum to treat intracavity, intraoral or intranasal sites Fee: \$411.75 Benefit: 75% = \$308.85 85% = \$354.65	
15348	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15342 or 15345 each attendance Fee: \$47.35 Benefit: 75% = \$35.55 85% = \$40.25	
15351	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD not exceeding 5 cm. diameter to an external surface Fee: \$94.55 Benefit: 75% = \$70.95 85% = \$80.40	
15354	CONSTRUCTION AND INITIAL APPLICATION OF RADIOACTIVE MOULD 5 cm. or more in diameter to an external surface Fee: \$114.80 Benefit: 75% = \$86.10 85% = \$97.60	
15357	SUBSEQUENT APPLICATIONS OF RADIOACTIVE MOULD referred to in item 15351 or 15354 each attendance Fee: \$32.40 Benefit: 75% = \$24.30 85% = \$27.55	
SUBGROUP 5 - COMPUTERISED PLANNING		
RADIOTHERAPY PLANNING		
15500	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15509 applies) (See para T2.2 of explanatory notes to this Category) Fee: \$196.80 Benefit: 75% = \$147.60 85% = \$167.30	
15503	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15512 applies) (See para T2.2 of explanatory notes to this Category) Fee: \$252.65 Benefit: 75% = \$189.50 85% = \$214.80	

RADIATION ONCOLOGY		STEREOTACTIC RADIOSURGERY	
15506	RADIATION FIELD SETTING using a simulator or isocentric xray or megavoltage machine of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15515 applies) <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$377.25 Benefit: 75% = \$282.95 85% = \$320.70		
15509	RADIATION FIELD SETTING using a diagnostic xray unit of a single area for treatment by a single field or parallel opposed fields (not being a service associated with a service to which item 15500 applies) <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$170.60 Benefit: 75% = \$127.95 85% = \$145.05		
15512	RADIATION FIELD SETTING using a diagnostic xray unit of a single area, where views in more than 1 plane are required for treatment by multiple fields, or of 2 areas (not being a service associated with a service to which item 15503 applies) <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$219.80 Benefit: 75% = \$164.85 85% = \$186.85		
15513	RADIATION SOURCE LOCALISATION using a simulator or x-ray machine of a single area, where views in more than 1 plane are required, for brachytherapy treatment planning for I125 seed implantation of localised prostate cancer, in association with item 15338 Fee: \$248.65 Benefit: 75% = \$186.50 85% = \$211.40		
15515	RADIATION FIELD SETTING using a diagnostic xray unit of 3 or more areas, or of total body or half body irradiation, or of mantle therapy or inverted Y fields, or of irregularly shaped fields using multiple blocks, or of offaxis fields or several joined fields (not being a service associated with a service to which item 15506 applies) <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$318.20 Benefit: 75% = \$238.65 85% = \$270.50		
15518	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$62.40 Benefit: 75% = \$46.80 85% = \$53.05		
15521	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$275.55 Benefit: 75% = \$206.70 85% = \$234.25		
15524	RADIATION DOSIMETRY by a CT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$516.75 Benefit: 75% = \$387.60 85% = \$459.65		
15527	RADIATION DOSIMETRY by a nonCT interfacing planning computer for megavoltage or teletherapy radiotherapy by a single field or parallel opposed fields to 1 area with up to 2 shielding blocks <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$63.95 Benefit: 75% = \$48.00 85% = \$54.40		
15530	RADIATION DOSIMETRY by a nonCT interfacing planning computer for megavoltage or teletherapy radiotherapy to a single area by 3 or more fields, or by a single field or parallel opposed fields to 2 areas, or where wedges are used <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$285.45 Benefit: 75% = \$214.10 85% = \$242.65		
15533	RADIATION DOSIMETRY by a nonCT interfacing planning computer for megavoltage or teletherapy radiotherapy to 3 or more areas, or by mantle fields or inverted Y fields, or tangential fields or irregularly shaped fields using multiple blocks, or offaxis fields, or several joined fields <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$541.30 Benefit: 75% = \$406.00 85% = \$484.20		
15536	BRACHYTHERAPY PLANNING, computerised radiation dosimetry <i>(See para T2.2 of explanatory notes to this Category)</i> Fee: \$216.35 Benefit: 75% = \$162.30 85% = \$183.90		
15539	BRACHYTHERAPY PLANNING, computerised radiation dosimetry for I125 seed implantation of localised prostate cancer, in association with item 15338 Fee: \$508.60 Benefit: 75% = \$381.45 85% = \$451.50		

SUBGROUP 6 - STEREOTACTIC RADIOSURGERY	
15600	STEREOTACTIC RADIOSURGERY, including all radiation oncology consultations, planning, simulation, dosimetry and treatment Fee: \$1,380.20 Benefit: 75% = \$1,035.15 85% = \$1,323.10

THERAPEUTIC NUCLEAR MEDICINE		THERAPEUTIC NUCLEAR MEDICINE	
GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE			
16003	INTRACAVITARY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 (not including preliminary paracentesis) (Anaes.) Fee: \$527.45	Benefit: 75% = \$395.60	85% = \$470.35
16006	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyroid cancer by single dose technique Fee: \$405.30	Benefit: 75% = \$304.00	85% = \$348.20
16009	ADMINISTRATION OF A THERAPEUTIC DOSE OF IODINE 131 for thyrotoxicosis by single dose technique Fee: \$276.60	Benefit: 75% = \$207.45	85% = \$235.15
16012	INTRAVENOUS ADMINISTRATION OF A THERAPEUTIC DOSE OF PHOSPHOROUS 32 Fee: \$239.30	Benefit: 75% = \$179.50	85% = \$203.45
16015	ADMINISTRATION OF STRONTIUM 89 for painful bony metastases from carcinoma of the prostate where hormone therapy has failed and either: (i) the disease is poorly controlled by conventional radiotherapy; or (ii) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain Fee: \$3,312.60	Benefit: 75% = \$2,484.45	85% = \$3,255.50
16018	ADMINISTRATION OF ¹⁵³ SM-LEXIDRONAM for the relief of bone pain due to skeletal metastases (as indicated by a positive bone scan) from either:- (i) carcinoma of the prostate, where hormonal therapy has failed; or (ii) carcinoma of the breast, where both hormonal therapy and chemotherapy have failed; and either:- (a) the disease is poorly controlled by conventional radiotherapy; or (b) conventional radiotherapy is inappropriate, due to the wide distribution of sites of bone pain Fee: \$1,980.25	Benefit: 75% = \$1,485.20	85% = \$1,923.15

OBSTETRICS		OBSTETRICS	
GROUP T4 - OBSTETRICS			
ANTENATAL CARE			
16500	ANTENATAL ATTENDANCE (See para T4.1 of explanatory notes to this Category) Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
16501	EXTERNAL CEPHALIC VERSION for breech presentation, after 36 weeks where no contraindication exists, in a Unit with facilities for Caesarean Section, including pre- and post version CTG, with or without tocolysis, not being a service to which items 55718 to 55728 and 55768 to 55774 apply - chargeable whether or not the version is successful and limited to a maximum of 2 ECV's per pregnancy (See para T4.2 of explanatory notes to this Category) Fee: \$113.95	Benefit: 75% = \$85.50	85% = \$96.90
16502	POLYHYDRAMNIOS, UNSTABLE LIE, MULTIPLE PREGNANCY, PREGNANCY COMPLICATED BY DIABETES OR ANAEMIA, THREATENED PREMATURE LABOUR treated by bed rest only or oral medication, requiring admission to hospital each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
16504	TREATMENT OF HABITUAL MISCARRIAGE by injection of hormones each injection up to a maximum of 12 injections, where the injection is not administered during a routine antenatal attendance Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
16505	THREATENED ABORTION, THREATENED MISCARRIAGE OR HYPEREMESIS GRAVIDARUM, requiring admission to hospital, treatment of each attendance that is not a routine antenatal attendance Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
16508	PREGNANCY COMPLICATED BY acute intercurrent infection, intrauterine growth retardation, threatened premature labour with ruptured membranes or threatened premature labour treated by intravenous therapy, requiring admission to hospital - each attendance that is not a routine antenatal attendance, to a maximum of 1 visit per day Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
16509	PREECLAMPSIA, ECLAMPSIA OR ANTEPARTUM HAEMORRHAGE, treatment of each attendance that is not a routine antenatal attendance Fee: \$29.45	Benefit: 75% = \$22.10	85% = \$25.05
16511	CERVIX, purse string ligation of (Anaes.) Fee: \$178.30	Benefit: 75% = \$133.75	85% = \$151.60
16512	CERVIX, removal of purse string ligature of (Anaes.) Fee: \$51.45	Benefit: 75% = \$38.60	85% = \$43.75
16514	ANTENATAL CARDIOTOGRAPHY in the management of high risk pregnancy (not during the course of the confinement) Fee: \$29.75	Benefit: 75% = \$22.35	85% = \$25.30
MANAGEMENT OF LABOUR AND DELIVERY			
@ 16515	MANAGEMENT OF VAGINAL DELIVERY as an independent procedure where the patient's care has been transferred by another medical practitioner for management of the delivery and the attending medical practitioner has not provided antenatal care to the patient, including all attendances related to the delivery (Anaes.) (See para T4.3 of explanatory notes to this Category) Fee: \$281.00	Benefit: 75% = \$210.75	85% = \$238.85
@ 16518	MANAGEMENT OF LABOUR, incomplete, where the patient's care has been transferred to another medical practitioner for completion of the delivery (Anaes.) (See para T4.3 of explanatory notes to this Category) Fee: \$281.00	Benefit: 75% = \$210.75	85% = \$238.85
@ 16519	MANAGEMENT OF LABOUR and delivery by any means (including Caesarean section) including post-partum care for 5 days (Anaes.) (See para T4.3 of explanatory notes to this Category) Fee: \$432.80	Benefit: 75% = \$324.60	85% = \$375.70

OBSTETRICS		OBSTETRICS
@ 16520	CAESAREAN SECTION and post-operative care for 7 days where the patient's care has been transferred by another medical practitioner for management of the confinement and the attending medical practitioner has not provided any of the antenatal care (Anaes.) (See para T4.4 of explanatory notes to this Category) Fee: \$505.75 Benefit: 75% = \$379.35 85% = \$448.65	
@ 16522	MANAGEMENT OF LABOUR AND DELIVERY, or delivery alone, (including Caesarean section), where in the course of antenatal supervision or intrapartum management 1 or more of the following conditions is present, including postnatal care for 7 days: - multiple pregnancy; - recurrent antepartum haemorrhage from 20 weeks gestation; - grades 2, 3 or 4 placenta praevia; - baby with a birth weight less than or equal to 2500gm; - preexisting diabetes mellitus dependent on medication, or gestational diabetes requiring at least daily blood; - glucose monitoring; - trial of vaginal delivery in a patient with uterine scar, or trial of vaginal breech delivery; - preexisting hypertension requiring antihypertensive medication, or pregnancy induced hypertension of at least 140/90mmHg associated with at least 1+ proteinuria on urinalysis; - prolonged labour greater than 12 hours with partogram evidence of abnormal cervimetric progress; - fetal distress defined by significant cardiotocograph or scalp pH abnormalities requiring immediate delivery; OR - conditions that pose a significant risk of maternal death. (Anaes.) (See para T4.5 of explanatory notes to this Category) Fee: \$1,016.20 Benefit: 75% = \$762.15 85% = \$959.10	
@ 16525	MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (Anaes.) (See para T4.3 of explanatory notes to this Category) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
POST-PARTUM CARE		
@ 16564	EVACUATION OF RETAINED PRODUCTS OF CONCEPTION (placenta, membranes or mole) as a complication of confinement, with or without curettage of the uterus, as an independent procedure (Anaes.) (See para T4.6 of explanatory notes to this Category) Fee: \$176.75 Benefit: 75% = \$132.60 85% = \$150.25	
@ 16567	MANAGEMENT OF POSTPARTUM HAEMORRHAGE by special measures such as packing of uterus, as an independent procedure (Anaes.) (See para T4.6 of explanatory notes to this Category) Fee: \$258.55 Benefit: 75% = \$193.95 85% = \$219.80	
@ 16570	ACUTE INVERSION OF THE UTERUS, vaginal correction of, as an independent procedure (Anaes.) (See para T4.6 of explanatory notes to this Category) Fee: \$337.30 Benefit: 75% = \$253.00 85% = \$286.75	
@ 16571	CERVIX, repair of extensive laceration or lacerations (Anaes.) (See para T4.6 of explanatory notes to this Category) Fee: \$258.55 Benefit: 75% = \$193.95 85% = \$219.80	
@ 16573	THIRD DEGREE TEAR, involving anal sphincter muscles and rectal mucosa, repair of, as an independent procedure (Anaes.) (See para T4.6 of explanatory notes to this Category) Fee: \$210.70 Benefit: 75% = \$158.05 85% = \$179.10	
INTERVENTIONAL TECHNIQUES		
16600	AMNIOCENTESIS, diagnostic (See para T4.7 of explanatory notes to this Category) Fee: \$51.45 Benefit: 75% = \$38.60 85% = \$43.75	
16603	CHORIONIC VILLUS SAMPLING, by any route (See para T4.7 of explanatory notes to this Category) Fee: \$98.85 Benefit: 75% = \$74.15 85% = \$84.05	

OBSTETRICS		OBSTETRICS
16606	FETAL BLOOD SAMPLING, using interventional techniques from umbilical cord or fetus, including fetal neuromuscular blockade and amniocentesis (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$197.15 Benefit: 75% = \$147.90 85% = \$167.60	
16609	FETAL INTRAVASCULAR BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$402.15 Benefit: 75% = \$301.65 85% = \$345.05	
16612	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - not performed in conjunction with a service described in item 16609 (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$316.40 Benefit: 75% = \$237.30 85% = \$268.95	
16615	FETAL INTRAPERITONEAL BLOOD TRANSFUSION, using blood already collected, including neuromuscular blockade, amniocentesis and fetal blood sampling - performed in conjunction with a service described in item 16609 (Anaes.) (See para T4.7 of explanatory notes to this Category) Fee: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20	
16618	AMNIOCENTESIS, THERAPEUTIC, when indicated because of polyhydramnios with at least 500ml being aspirated (See para T4.7 of explanatory notes to this Category) Fee: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20	
16621	AMNIOINFUSION, for diagnostic or therapeutic purposes in the presence of severe oligohydramnios (See para T4.7 of explanatory notes to this Category) Fee: \$168.45 Benefit: 75% = \$126.35 85% = \$143.20	
16624	FETAL FLUID FILLED CAVITY, drainage of (See para T4.7 of explanatory notes to this Category) Fee: \$242.50 Benefit: 75% = \$181.90 85% = \$206.15	
16627	FETO-AMNIOTIC SHUNT, insertion of, into fetal fluid filled cavity, including neuromuscular blockade and amniocentesis (See para T4.7 of explanatory notes to this Category) Fee: \$493.70 Benefit: 75% = \$370.30 85% = \$436.60	
16633	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16606 , 16609 , 16612 , 16615 and 16627 (See para T4.7 of explanatory notes to this Category) Derived Fee: 50% of the fee for the first foetus for any additional foetus tested	
16636	PROCEDURE ON MULTIPLE PREGNANCIES relating to items 16600 , 16603 , 16618 , 16621 and 16624 (See para T4.7 of explanatory notes to this Category) Derived Fee: 50% of the fee for the first foetus for any additional foetus tested	

ANAESTHETICS		EXAMINATION
GROUP T6 - ANAESTHETICS		
SUBGROUP 1 - EXAMINATION BY AN ANAESTHETIST		
17603	EXAMINATION OF A PATIENT IN PREPARATION FOR THE ADMINISTRATION OF AN ANAESTHETIC RELATING TO A CLINICALLY RELEVANT SERVICE, being an examination carried out at a place other than an operating theatre or an anaesthetic induction room (See para T6.1 of explanatory notes to this Category) Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60	
REGIONAL OR FIELD NERVE BLOCKS		REGIONAL OR FIELD NERVE BLOCKS
GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS		
18213	INTRAVENOUS REGIONAL ANAESTHESIA of limb by retrograde perfusion Fee: \$71.90 Benefit: 75% = \$53.95 85% = \$61.15	
@ 18216	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.) Fee: \$153.95 Benefit: 75% = \$115.50 85% = \$130.90	
@ 18219	INTRATHECAL or EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by the medical practitioner extends beyond the first hour (Anaes.) Derived Fee: The fee for item 18216 plus \$15.45 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner	
18222	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is 15 minutes or less (See para T7.2 of explanatory notes to this Category) Fee: \$30.50 Benefit: 75% = \$22.90 85% = \$25.95	
18225	INFUSION OF A THERAPEUTIC SUBSTANCE to maintain regional anaesthesia or analgesia, subsequent injection or revision of, where the period of continuous medical practitioner attendance is more than 15 minutes (See para T7.2 of explanatory notes to this Category) Fee: \$40.65 Benefit: 75% = \$30.50 85% = \$34.60	
18226	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, including up to hour of continuous attendance by the medical practitioner, for a patient in labour , where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. (See para T7.5 of explanatory notes to this Category) Fee: \$225.30 Benefit: 75% = \$169.00 85% = \$191.55	
18227	INTRATHECAL OR EPIDURAL INFUSION of a therapeutic substance, initial injection or commencement of, where continuous attendance by a medical practitioner extends beyond the first hour, for a patient in labour , where the service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or any time on a Saturday, a Sunday or a public holiday. (See para T7.5 of explanatory notes to this Category) Derived Fee: The fee for item 18226 plus \$22.60 for each additional 15 minutes or part thereof beyond the first hour of attendance by the medical practitioner.	
18228	INTERPLEURAL BLOCK, initial injection or commencement of infusion of a therapeutic substance Fee: \$50.70 Benefit: 75% = \$38.05 85% = \$43.10	
@ 18230	INTRATHECAL or EPIDURAL INJECTION of neurolytic substance (Anaes.) Fee: \$193.30 Benefit: 75% = \$145.00 85% = \$164.35	
@ 18232	INTRATHECAL or EPIDURAL INJECTION of substance other than anaesthetic, contrast or neurolytic solutions, not being a service to which another item in this Group applies (Anaes.) (See para T7.3 of explanatory notes to this Category) Fee: \$153.95 Benefit: 75% = \$115.50 85% = \$130.90	
@ 18233	EPIDURAL INJECTION of blood for blood patch (Anaes.) Fee: \$153.95 Benefit: 75% = \$115.50 85% = \$130.90	
@ 18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) Fee: \$101.20 Benefit: 75% = \$75.90 85% = \$86.05	

REGIONAL OR FIELD NERVE BLOCKS		REGIONAL OR FIELD NERVE BLOCKS	
@ 18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies Fee: \$30.50	Benefit: 75% = \$22.90	85% = \$25.95
18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent Fee: \$75.85	Benefit: 75% = \$56.90	85% = \$64.50
@ 18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) Fee: \$30.50	Benefit: 75% = \$22.90	85% = \$25.95
18244	VAGUS NERVE, injection of an anaesthetic agent Fee: \$81.70	Benefit: 75% = \$61.30	85% = \$69.45
18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent Fee: \$81.70	Benefit: 75% = \$61.30	85% = \$69.45
18248	PHRENIC NERVE, injection of an anaesthetic agent Fee: \$71.90	Benefit: 75% = \$53.95	85% = \$61.15
18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18252	CERVICAL PLEXUS, injection of an anaesthetic agent Fee: \$81.70	Benefit: 75% = \$61.30	85% = \$69.45
18254	BRACHIAL PLEXUS, injection of an anaesthetic agent Fee: \$81.70	Benefit: 75% = \$61.30	85% = \$69.45
18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent Fee: \$71.90	Benefit: 75% = \$53.95	85% = \$61.15
@ 18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18264	PUDENDAL NERVE, injection of an anaesthetic agent Fee: \$81.70	Benefit: 75% = \$61.30	85% = \$69.45
18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18268	OBTURATOR NERVE, injection of an anaesthetic agent Fee: \$71.90	Benefit: 75% = \$53.95	85% = \$61.15
18270	FEMORAL NERVE, injection of an anaesthetic agent Fee: \$71.90	Benefit: 75% = \$53.95	85% = \$61.15
18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent Fee: \$50.70	Benefit: 75% = \$38.05	85% = \$43.10
18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) Fee: \$71.90	Benefit: 75% = \$53.95	85% = \$61.15
18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) Fee: \$101.20	Benefit: 75% = \$75.90	85% = \$86.05

REGIONAL OR FIELD NERVE BLOCKS		REGIONAL OR FIELD NERVE BLOCKS	
18278	SCIATIC NERVE, injection of an anaesthetic agent Fee: \$71.90 Benefit: 75% = \$53.95 85% = \$61.15		
@ 18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) Fee: \$101.20 Benefit: 75% = \$75.90 85% = \$86.05		
18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure Fee: \$81.70 Benefit: 75% = \$61.30 85% = \$69.45		
@ 18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) Fee: \$119.70 Benefit: 75% = \$89.80 85% = \$101.75		
@ 18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) Fee: \$119.70 Benefit: 75% = \$89.80 85% = \$101.75		
@ 18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) Fee: \$119.70 Benefit: 75% = \$89.80 85% = \$101.75		
@ 18290	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent (Anaes.) Fee: \$202.50 Benefit: 75% = \$151.90 85% = \$172.15		
@ 18292	NERVE BRANCH, destruction by a neurolytic agent, not being a service to which any other item in this Group applies (Anaes.) <i>(See para T7.4 of explanatory notes to this Category)</i> Fee: \$101.20 Benefit: 75% = \$75.90 85% = \$86.05		
@ 18294	COELIAC PLEXUS OR SPLANCHNIC NERVES, destruction by a neurolytic agent (Anaes.) Fee: \$142.70 Benefit: 75% = \$107.05 85% = \$121.30		
@ 18296	LUMBAR SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) Fee: \$122.00 Benefit: 75% = \$91.50 85% = \$103.70		
@ 18298	CERVICAL OR THORACIC SYMPATHETIC CHAIN, destruction by a neurolytic agent (Anaes.) Fee: \$142.70 Benefit: 75% = \$107.05 85% = \$121.30		

RELATIVE VALUE GUIDE		HEAD
GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE		
SUBGROUP 1 - HEAD		
+ 20100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, subcutaneous tissue, muscles, salivary glands or superficial vessels of the head including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20102	INITIATION OF MANAGEMENT OF ANAESTHESIA for plastic repair of cleft lip (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20104	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroconvulsive therapy (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on external, middle or inner ear, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20124	INITIATION OF MANAGEMENT OF ANAESTHESIA for otoscopy (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20140	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on eye, not being a service to which another item in this Group applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20142	INITIATION OF MANAGEMENT OF ANAESTHESIA for lens surgery (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20143	INITIATION OF MANAGEMENT OF ANAESTHESIA for retinal surgery (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20144	INITIATION OF MANAGEMENT OF ANAESTHESIA for corneal transplant (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 20145	INITIATION OF MANAGEMENT OF ANAESTHESIA for vitrectomy (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 20146	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of conjunctiva (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20148	INITIATION OF MANAGEMENT OF ANAESTHESIA for ophthalmoscopy (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20160	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nose or accessory sinuses, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20162	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on the nose and accessory sinuses (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20164	INITIATION OF MANAGEMENT OF ANAESTHESIA for biopsy of soft tissue of the nose and accessory sinuses (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20170	INITIATION OF MANAGEMENT OF ANAESTHESIA for intraoral procedures, including biopsy, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20172	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of cleft palate (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20174	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision of retropharyngeal tumour (9 basic units) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25	

RELATIVE VALUE GUIDE **NECK**

+	20176	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical intraoral surgery (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+	20190	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on facial bones, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	20192	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive surgery on facial bones (including prognathism and extensive facial bone reconstruction) (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+	20210	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial procedures, not being a service to which another item in this Subgroup applies (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40
+	20212	INITIATION OF MANAGEMENT OF ANAESTHESIA for subdural taps (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	20214	INITIATION OF MANAGEMENT OF ANAESTHESIA for burr holes of the cranium (9 basic units) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25
+	20216	INITIATION OF MANAGEMENT OF ANAESTHESIA for intracranial vascular procedures including those for aneurysms or arterio-venous abnormalities (20 basic units) Fee: \$330.00 Benefit: 75% = \$247.50 85% = \$280.50
+	20220	INITIATION OF MANAGEMENT OF ANAESTHESIA for spinal fluid shunt procedures (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+	20222	INITIATION OF MANAGEMENT OF ANAESTHESIA for ablation of an intracranial nerve (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+	20225	INITIATION OF MANAGEMENT OF ANAESTHESIA for all cranial bone procedures (12 basic units) Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
SUBGROUP 2 - NECK		
+	20300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the neck not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	20305	INITIATION OF MANAGEMENT OF ANAESTHESIA for incision and drainage of large haematoma, large abscess, cellulitis or similar lesion or epiglottitis causing life threatening airway obstruction (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40
+	20320	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on oesophagus, thyroid, larynx, trachea, lymphatic system, muscles, nerves or other deep tissues of the neck, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+	20321	INITIATION OF MANAGEMENT OF ANAESTHESIA for laryngectomy, hemi laryngectomy, laryngopharyngectomy or pharyngectomy (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+	20330	INITIATION OF MANAGEMENT OF ANAESTHESIA for laser surgery to the airway (excluding nose and mouth) (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20
+	20350	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major vessels of neck, not being a service to which another item in this Subgroup applies (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+	20352	INITIATION OF MANAGEMENT OF ANAESTHESIA for simple ligation of major vessels of neck (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15

SUBGROUP 3 - THORAX	
+ 20400	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior part of the chest, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10
+ 20401	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the breast, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+ 20402	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on breast (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20403	INITIATION OF MANAGEMENT OF ANAESTHESIA for removal of breast lump or for breast segmentectomy where axillary node dissection is performed (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20404	INITIATION OF MANAGEMENT OF ANAESTHESIA for mastectomy (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20405	INITIATION OF MANAGEMENT OF ANAESTHESIA for reconstructive procedures on the breast using myocutaneous flaps (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20
+ 20406	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical or modified radical procedures on breast with internal mammary node dissection (13 basic units) Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35
+ 20410	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrical conversion of arrhythmias (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20420	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the posterior part of the chest not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20450	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on clavicle, scapula or sternum, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20452	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical surgery on clavicle, scapula or sternum (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20470	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial rib resection, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20472	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoplasty (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+ 20474	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on chest wall (13 basic units) <i>(See para T10.21 of explanatory notes to this Category)</i> Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35
SUBGROUP 4 - INTRATHORACIC	
+ 20500	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the oesophagus (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40
+ 20520	INITIATION OF MANAGEMENT OF ANAESTHESIA for all closed chest procedures (including rigid oesophagoscopy or bronchoscopy), not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20522	INITIATION OF MANAGEMENT OF ANAESTHESIA for needle biopsy of pleura (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+ 20524	INITIATION OF MANAGEMENT OF ANAESTHESIA for pneumocentesis (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10

RELATIVE VALUE GUIDE		SPINE AND SPINAL CORD
+ 20526	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracoscopy (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20528	INITIATION OF MANAGEMENT OF ANAESTHESIA for mediastinoscopy (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 20540	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracotomy procedures involving lungs, pleura, diaphragm, or mediastinum, not being a service to which another item in this Subgroup applies (13 basic units) Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35	
+ 20542	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary decortication (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 20546	INITIATION OF MANAGEMENT OF ANAESTHESIA for pulmonary resection with thoracoplasty (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 20548	INITIATION OF MANAGEMENT OF ANAESTHESIA for intrathoracic repair of trauma to trachea and bronchi (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 20560	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the heart, pericardium or great vessels of chest (20 basic units) Fee: \$330.00 Benefit: 75% = \$247.50 85% = \$280.50	
SUBGROUP 5 - SPINE AND SPINAL CORD		
+ 20600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on cervical spine and/or cord, not being a service to which another item in this Subgroup applies (for myelography and discography see Items 21908 and 21914) (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20604	INITIATION OF MANAGEMENT OF ANAESTHESIA for posterior cervical laminectomy with the patient in the sitting position (13 basic units) Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35	
+ 20620	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on thoracic spine and/or cord, not being a service to which another item in this Subgroup applies (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20622	INITIATION OF MANAGEMENT OF ANAESTHESIA for thoracolumbar sympathectomy (13 basic units) Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35	
+ 20630	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures in lumbar region, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 20632	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar sympathectomy (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20634	INITIATION OF MANAGEMENT OF ANAESTHESIA for chemonucleolysis (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20670	INITIATION OF MANAGEMENT OF ANAESTHESIA for extensive spine and/or spinal cord procedures (13 basic units) <i>(See para T10.22 of explanatory notes to this Category)</i> Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35	
+ 20680	INITIATION OF MANAGEMENT OF ANAESTHESIA for manipulation of spine when performed in the operating theatre of a hospital or day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 20690	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous spinal procedures, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
SUBGROUP 6 - UPPER ABDOMEN		
+ 20700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper anterior abdominal wall, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	

RELATIVE VALUE GUIDE		UPPER ABDOMEN
+ 20702	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous liver biopsy (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20705	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopy procedures (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20706	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the upper abdomen, not being a service to which another item in this Subgroup applies (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20730	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper posterior abdominal wall, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20740	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20745	INITIATION OF MANAGEMENT OF ANAESTHESIA for upper gastrointestinal endoscopic procedures in association with acute gastrointestinal haemorrhage (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20750	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in upper abdomen, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20752	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional hernia and/or wound dehiscence (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20754	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on an omphalocele (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20756	INITIATION OF MANAGEMENT OF ANAESTHESIA for transabdominal repair of diaphragmatic hernia (9 basic units) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25	
+ 20770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major upper abdominal blood vessels (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 20790	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures within the peritoneal cavity in upper abdomen including cholecystectomy, gastrectomy, laparoscopic nephrectomy or bowel shunts (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 20791	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastric reduction or gastroplasty for the treatment of morbid obesity (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20792	INITIATION OF MANAGEMENT OF ANAESTHESIA for partial hepatectomy (excluding liver biopsy) (13 basic units) Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35	
+ 20793	INITIATION OF MANAGEMENT OF ANAESTHESIA for extended or trisegmental hepatectomy (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 20794	INITIATION OF MANAGEMENT OF ANAESTHESIA for pancreatectomy, partial or total (12 basic units) Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30	
+ 20798	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the upper abdomen (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
20799	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the upper abdomen (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	

SUBGROUP 7 - LOWER ABDOMEN	
+ 20800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the lower anterior abdominal walls, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10
+ 20802	INITIATION OF MANAGEMENT OF ANAESTHESIA for lipectomy of the lower abdomen (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20805	INITIATION OF MANAGEMENT OF ANAESTHESIA for diagnostic laparoscopic procedures (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20806	INITIATION OF MANAGEMENT OF ANAESTHESIA for laparoscopic procedures in the lower abdomen (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20
+ 20810	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower intestinal endoscopic procedures (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+ 20815	INITIATION OF MANAGEMENT OF ANAESTHESIA for extracorporeal shock wave lithotripsy to urinary tract (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20820	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the lower posterior abdominal wall (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+ 20830	INITIATION OF MANAGEMENT OF ANAESTHESIA for hernia repairs in lower abdomen, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+ 20832	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of incisional herniae and/or wound dehiscence of the lower abdomen (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20840	INITIATION OF MANAGEMENT OF ANAESTHESIA for all procedures within the peritoneal cavity in lower abdomen including appendectomy, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+ 20841	INITIATION OF MANAGEMENT OF ANAESTHESIA for bowel resection, including laparoscopic bowel resection not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20
+ 20842	INITIATION OF MANAGEMENT OF ANAESTHESIA for amniocentesis (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+ 20844	INITIATION OF MANAGEMENT OF ANAESTHESIA for abdominoperineal resection, including pull through procedures, ultra low anterior resection and formation of bowel reservoir (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+ 20845	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical prostatectomy (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+ 20846	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical hysterectomy (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+ 20848	INITIATION OF MANAGEMENT OF ANAESTHESIA for pelvic exenteration (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25
+ 20850	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarean section (12 basic units) Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30
+ 20855	INITIATION OF MANAGEMENT OF ANAESTHESIA for Caesarian hysterectomy or hysterectomy within 24 hours of delivery (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40

RELATIVE VALUE GUIDE		PERINEUM
+ 20860	INITIATION OF MANAGEMENT OF ANAESTHESIA for extraperitoneal procedures in lower abdomen, including those on the urinary tract, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 20862	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal procedures, including upper 1/3 of ureter (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20864	INITIATION OF MANAGEMENT OF ANAESTHESIA for total cystectomy (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20866	INITIATION OF MANAGEMENT OF ANAESTHESIA for adrenalectomy (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20867	INITIATION OF MANAGEMENT OF ANAESTHESIA for neuro endocrine tumour removal in the lower abdomen (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20868	INITIATION OF MANAGEMENT OF ANAESTHESIA for renal transplantation (donor or recipient) (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20880	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on major lower abdominal vessels, not being a service to which another item in this subgroup applies (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 20882	INITIATION OF MANAGEMENT OF ANAESTHESIA for inferior vena cava ligation (10 basic units) Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25	
+ 20884	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous umbrella insertion (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
20886	INITIATION OF MANAGEMENT OF ANAESTHESIA for percutaneous procedures on an intra-abdominal organ in the lower abdomen (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
SUBGROUP 8 - PERINEUM		
+ 20900	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the perineum (including biopsy of male genital system), not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 20902	INITIATION OF MANAGEMENT OF ANAESTHESIA for anorectal procedures (including endoscopy and/or biopsy) (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20904	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical perineal procedures including radical perineal prostatectomy or radical vulvectomy (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20906	INITIATION OF MANAGEMENT OF ANAESTHESIA for vulvectomy (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20910	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral procedures (including urethrocytscopy), not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 20912	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of bladder tumour(s) (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 20914	INITIATION OF MANAGEMENT OF ANAESTHESIA for transurethral resection of prostate (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20916	INITIATION OF MANAGEMENT OF ANAESTHESIA for bleeding post-transurethral resection (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 20920	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on male external genitalia, not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	

RELATIVE VALUE GUIDE		PERINEUM	
+ 20924	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on undescended testis, unilateral or bilateral (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20926	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, inguinal approach (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20928	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical orchidectomy, abdominal approach (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15
+ 20930	INITIATION OF MANAGEMENT OF ANAESTHESIA for orchiopexy, unilateral or bilateral (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20932	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20934	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal lymphadenectomy (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15
+ 20936	INITIATION OF MANAGEMENT OF ANAESTHESIA for complete amputation of penis with bilateral inguinal and iliac lymphadenectomy (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 20938	INITIATION OF MANAGEMENT OF ANAESTHESIA for insertion of penile prosthesis (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20940	INITIATION OF MANAGEMENT OF ANAESTHESIA for per vagina and vaginal procedures (including biopsy of labia, vagina, cervix or endometrium), not being a service to which another item in this Subgroup applies (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
+ 20942	INITIATION OF MANAGEMENT OF ANAESTHESIA for colpotomy, colpectomy or colporrhaphy (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20943	INITIATION OF MANAGEMENT OF ANAESTHESIA for transvaginal assisted reproductive services (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20944	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal hysterectomy (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15
+ 20946	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal delivery (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 20948	INITIATION OF MANAGEMENT OF ANAESTHESIA for purse string ligation of cervix, or removal of purse string ligature (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20950	INITIATION OF MANAGEMENT OF ANAESTHESIA for culdoscopy (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 20952	INITIATION OF MANAGEMENT OF ANAESTHESIA for hysteroscopy (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20954	INITIATION OF MANAGEMENT OF ANAESTHESIA for correction of inverted uterus (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 20956	INITIATION OF MANAGEMENT OF ANAESTHESIA for evacuation of retained products of conception, as a complication of confinement (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 20958	INITIATION OF MANAGEMENT OF ANAESTHESIA for manual removal of retained placenta or for repair of vaginal or perineal tear following delivery (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 20960	INITIATION OF MANAGEMENT OF ANAESTHESIA for vaginal procedures in the management of post partum haemorrhage (blood loss > 500mls) (7 basic units) Fee: \$115.50	Benefit: 75% = \$86.65	85% = \$98.20

		SUBGROUP 9 - PELVIS (EXCEPT HIP)	
+	21100	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the anterior pelvic region (anterior to iliac crest), except external genitalia (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15 85% = \$42.10
+	21110	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin, its derivatives or subcutaneous tissue of the pelvic region (posterior to iliac crest), except perineum (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90 85% = \$70.15
+	21120	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the bony pelvis (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
+	21130	INITIATION OF MANAGEMENT OF ANAESTHESIA for body cast application or revision when performed in the operating theatre of a hospital or day hospital facility (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15 85% = \$42.10
+	21140	INITIATION OF MANAGEMENT OF ANAESTHESIA for interpelviabdominal (hind-quarter) amputation (15 basic units) Fee: \$247.50	Benefit: 75% = \$185.65 85% = \$210.40
+	21150	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures for tumour of the pelvis, except hind-quarter amputation (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75 85% = \$140.25
+	21160	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving symphysis pubis or sacroiliac joint when performed in the operating theatre of a hospital or day hospital facility (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50 85% = \$56.10
+	21170	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving symphysis pubis or sacroiliac joint (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00 85% = \$112.20
SUBGROUP 10 - UPPER LEG (EXCEPT KNEE)			
+	21195	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper leg (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15 85% = \$42.10
+	21199	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of the upper leg (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50 85% = \$56.10
+	21200	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving hip joint when performed in the operating theatre of a hospital or day hospital facility (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50 85% = \$56.10
+	21202	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the hip joint (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50 85% = \$56.10
+	21210	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving hip joint, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15
+	21212	INITIATION OF MANAGEMENT OF ANAESTHESIA for hip disarticulation (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75 85% = \$140.25
+	21214	INITIATION OF MANAGEMENT OF ANAESTHESIA for total hip replacement or revision (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75 85% = \$140.25
+	21220	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures involving upper 2/3 of femur when performed in the operating theatre of a hospital or day hospital facility (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50 85% = \$56.10
+	21230	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures involving upper 2/3 of femur, not being a service to which another item in this Subgroup applies (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25 85% = \$84.15

RELATIVE VALUE GUIDE		KNEE AND POPLITEAL AREA	
+ 21232	INITIATION OF MANAGEMENT OF ANAESTHESIA for above knee amputation (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21234	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of the upper 2/3 of femur (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 21260	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving veins of upper leg, including exploration (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21270	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures involving arteries of upper leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 21272	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery ligation (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21274	INITIATION OF MANAGEMENT OF ANAESTHESIA for femoral artery embolectomy (6 basic units) (<i>See para T10.23 of explanatory notes to this Category</i>) Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15
+ 21280	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper leg (15 basic units) Fee: \$247.50	Benefit: 75% = \$185.65	85% = \$210.40
SUBGROUP 11 - KNEE AND POPLITEAL AREA			
+ 21300	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the knee and/or popliteal area (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
+ 21321	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of knee and/or popliteal area (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21340	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower 1/3 of femur when performed in the operating theatre of a hospital or day hospital facility (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21360	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on lower 1/3 of femur (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21380	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on knee joint when performed in the operating theatre of a hospital or day hospital facility (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
+ 21382	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of knee joint (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21390	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on upper ends of tibia, fibula, and/or patella when performed in the operating theatre of a hospital or day hospital facility (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
+ 21392	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on upper ends of tibia, fibula, and/or patella (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21400	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on knee joint, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21402	INITIATION OF MANAGEMENT OF ANAESTHESIA for knee replacement (7 basic units) Fee: \$115.50	Benefit: 75% = \$86.65	85% = \$98.20
+ 21403	INITIATION OF MANAGEMENT OF ANAESTHESIA for bilateral knee replacement (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25

RELATIVE VALUE GUIDE		LOWER LEG
+ 21404	INITIATION OF MANAGEMENT OF ANAESTHESIA for disarticulation of knee (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21420	INITIATION OF MANAGEMENT OF ANAESTHESIA for cast application, removal, or repair involving knee joint, undertaken in a hospital or approved day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21430	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of knee or popliteal area, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21432	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of arteriovenous fistula of knee or popliteal area (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21440	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of knee or popliteal area, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
SUBGROUP 12 - LOWER LEG (BELOW KNEE)		
+ 21460	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of lower leg, ankle, or foot (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21461	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, or fascia of lower leg, ankle, or foot, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21462	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on lower leg, ankle, or foot (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21464	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedure of ankle joint (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21472	INITIATION OF MANAGEMENT OF ANAESTHESIA for repair of Achilles tendon (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21474	INITIATION OF MANAGEMENT OF ANAESTHESIA for gastrocnemius recession (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21480	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on bones of lower leg, ankle, or foot, including amputation, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21482	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection of bone involving lower leg, ankle or foot (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21484	INITIATION OF MANAGEMENT OF ANAESTHESIA for osteotomy or osteoplasty of tibia or fibula (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21486	INITIATION OF MANAGEMENT OF ANAESTHESIA for total ankle replacement (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 21490	INITIATION OF MANAGEMENT OF ANAESTHESIA for lower leg cast application, removal or repair, undertaken in a hospital or approved day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21500	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of lower leg, including bypass graft, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 21502	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of the lower leg (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	

RELATIVE VALUE GUIDE		SHOULDER AND AXILLA	
+ 21520	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of lower leg, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21522	INITIATION OF MANAGEMENT OF ANAESTHESIA for venous thrombectomy of the lower leg (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21530	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of lower leg, ankle or foot (15 basic units) Fee: \$247.50	Benefit: 75% = \$185.65	85% = \$210.40
+ 21532	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of toe (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
SUBGROUP 13 - SHOULDER AND AXILLA			
+ 21600	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the shoulder or axilla (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
+ 21610	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of shoulder or axilla including axillary dissection (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21620	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, or shoulder joint when performed in the operating theatre of a hospital or day hospital facility (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10
+ 21622	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of shoulder joint (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21630	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21632	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical resection involving humeral head and neck, sternoclavicular joint, acromioclavicular joint or shoulder joint (6 basic units) Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15
+ 21634	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder disarticulation (9 basic units) Fee: \$148.50	Benefit: 75% = \$111.40	85% = \$126.25
+ 21636	INITIATION OF MANAGEMENT OF ANAESTHESIA for interthoracoscapular (forequarter) amputation (15 basic units) Fee: \$247.50	Benefit: 75% = \$185.65	85% = \$210.40
+ 21638	INITIATION OF MANAGEMENT OF ANAESTHESIA for total shoulder replacement (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 21650	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of shoulder or axilla, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 21652	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures for axillary-brachial aneurysm (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 21654	INITIATION OF MANAGEMENT OF ANAESTHESIA for bypass graft of arteries of shoulder or axilla (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 21656	INITIATION OF MANAGEMENT OF ANAESTHESIA for axillary-femoral bypass graft (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 21670	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of shoulder or axilla (4 basic units) Fee: \$66.00	Benefit: 75% = \$49.50	85% = \$56.10

RELATIVE VALUE GUIDE **UPPER ARM AND ELBOW**

+	21680	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder cast application, removal or repair, not being a service to which another item in this Subgroup applies, when undertaken in a hospital or approved day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10
+	21682	INITIATION OF MANAGEMENT OF ANAESTHESIA for shoulder spica application when undertaken in a hospital or approved day hospital facility (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
SUBGROUP 14 - UPPER ARM AND ELBOW		
+	21700	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the upper arm or elbow (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10
+	21710	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on nerves, muscles, tendons, fascia or bursae of upper arm or elbow, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+	21712	INITIATION OF MANAGEMENT OF ANAESTHESIA for open tenotomy of the upper arm or elbow (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	21714	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenoplasty of the upper arm or elbow (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	21716	INITIATION OF MANAGEMENT OF ANAESTHESIA for tenodesis for rupture of long tendon of biceps (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	21730	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the upper arm or elbow when performed in the operating theatre of a hospital or day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10
+	21732	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of elbow joint (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+	21740	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the upper arm or elbow, not being a service to which another item in this Subgroup applies (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15
+	21756	INITIATION OF MANAGEMENT OF ANAESTHESIA for radical procedures on the upper arm or elbow (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+	21760	INITIATION OF MANAGEMENT OF ANAESTHESIA for total elbow replacement (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20
+	21770	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on arteries of upper arm, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20
+	21772	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of arteries of the upper arm (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
+	21780	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on veins of upper arm, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10
+	21790	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of upper arm (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40
SUBGROUP 15 - FOREARM WRIST AND HAND		
+	21800	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the skin or subcutaneous tissue of the forearm, wrist or hand (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10
+	21810	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the nerves, muscles, tendons, fascia, or bursae of the forearm, wrist or hand (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10

RELATIVE VALUE GUIDE		ANAESTHESIA FOR BURNS
+ 21820	INITIATION OF MANAGEMENT OF ANAESTHESIA for closed procedures on the radius, ulna, wrist, or hand bones when performed in the operating theatre of a hospital or day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21830	INITIATION OF MANAGEMENT OF ANAESTHESIA for open procedures on the radius, ulna, wrist, or hand bones, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21832	INITIATION OF MANAGEMENT OF ANAESTHESIA for total wrist replacement (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 21834	INITIATION OF MANAGEMENT OF ANAESTHESIA for arthroscopic procedures of the wrist joint (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21840	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the arteries of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 21842	INITIATION OF MANAGEMENT OF ANAESTHESIA for embolectomy of artery of forearm, wrist or hand (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 21850	INITIATION OF MANAGEMENT OF ANAESTHESIA for procedures on the veins of forearm, wrist or hand, not being a service to which another item in this Subgroup applies (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 21860	INITIATION OF MANAGEMENT OF ANAESTHESIA for forearm, wrist, or hand cast application, removal, or repair when undertaken in a hospital or approved day hospital facility (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21870	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of forearm, wrist or hand (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	
+ 21872	INITIATION OF MANAGEMENT OF ANAESTHESIA for microsurgical reimplantation of a finger (8 basic units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
SUBGROUP 16 - ANAESTHESIA FOR BURNS		
+ 21878	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting where the area of burn involves not more than 3% of total body surface (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 21879	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves more than 3% but less than 10% of total body surface (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 21880	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 10% or more but less than 20% of total body surface (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 21881	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 20% or more but less than 30% of total body surface (9 basic units) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25	
+ 21882	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 30% or more but less than 40% of total body surface (11 basic units) Fee: \$181.50 Benefit: 75% = \$136.15 85% = \$154.30	
+ 21883	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 40% or more but less than 50% of total body surface (13 basic units) Fee: \$214.50 Benefit: 75% = \$160.90 85% = \$182.35	
+ 21884	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 50% or more but less than 60% of total body surface (15 basic units) Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40	

RELATIVE VALUE GUIDE		ANAESTHESIA FOR RADIOLOGICAL	
+ 21885	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 60% or more but less than 70% of total body surface (17 basic units) Fee: \$280.50 Benefit: 75% = \$210.40 85% = \$238.45		
+ 21886	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 70% or more but less than 80% of total body surface (19 basic units) Fee: \$313.50 Benefit: 75% = \$235.15 85% = \$266.50		
+ 21887	INITIATION OF MANAGEMENT OF ANAESTHESIA for excision or debridement of burns, with or without skin grafting, where the area of burn involves 80% or more of total body surface (21 basic units) Fee: \$346.50 Benefit: 75% = \$259.90 85% = \$294.55		
SUBGROUP 17 - ANAESTHESIA FOR RADIOLOGICAL OR OTHER DIAGNOSTIC OR THERAPEUTIC PROCEDURES			
+ 21900	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for hysterosalpingography (3 basic units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10		
+ 21906	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: lumbar or thoracic (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21908	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: cervical (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
+ 21910	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for myelography: posterior fossa (9 basic units) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25		
+ 21912	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: lumbar or thoracic (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21914	INITIATION OF MANAGEMENT OF ANAESTHESIA for injection procedure for discography: cervical (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
+ 21915	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral arteriogram (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21916	INITIATION OF MANAGEMENT OF ANAESTHESIA for arteriograms: cerebral, carotid or vertebral (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21918	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde arteriogram: brachial or femoral (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21922	INITIATION OF MANAGEMENT OF ANAESTHESIA for computerised axial tomography scanning, magnetic resonance scanning, digital subtraction angiography scanning (7 basic units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20		
+ 21925	INITIATION OF MANAGEMENT OF ANAESTHESIA for retrograde cystography, retrograde urethrography or retrograde cystourethrography (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+ 21926	INITIATION OF MANAGEMENT OF ANAESTHESIA for fluoroscopy (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21927	INITIATION OF MANAGEMENT OF ANAESTHESIA for 1 barium enema or other opaque study of the small bowel (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		
+ 21930	INITIATION OF MANAGEMENT OF ANAESTHESIA for bronchography (6 basic units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
+ 21935	INITIATION OF MANAGEMENT OF ANAESTHESIA for phlebography (5 basic units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15		

RELATIVE VALUE GUIDE		ANAESTHESIA FOR RADIOLOGICAL	
+ 21936	INITIATION OF MANAGEMENT OF ANAESTHESIA for heart, 2 dimensional real time transoesophageal examination (6 basic units) <i>(See para T10.25 of explanatory notes to this Category)</i> Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15
+ 21939	INITIATION OF MANAGEMENT OF ANAESTHESIA for peripheral venous cannulation (3 basic units) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
+ 21941	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac catheterisation including coronary arteriography, ventriculography, cardiac mapping, insertion of automatic defibrillator or transvenous pacemaker (7 basic units) <i>(See para T10.24 of explanatory notes to this Category)</i> Fee: \$115.50	Benefit: 75% = \$86.65	85% = \$98.20
+ 21942	INITIATION OF MANAGEMENT OF ANAESTHESIA for cardiac electrophysiological procedures including radio frequency ablation (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 21943	INITIATION OF MANAGEMENT OF ANAESTHESIA for central vein catheterisation or insertion of right heart balloon catheter (via jugular, subclavian or femoral vein) by percutaneous or open exposure (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21945	INITIATION OF MANAGEMENT OF ANAESTHESIA for lumbar puncture, cisternal puncture, or epidural injection (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21949	INITIATION OF MANAGEMENT OF ANAESTHESIA for harvesting of bone marrow for the purpose of transplantation (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21952	INITIATION OF MANAGEMENT OF ANAESTHESIA for muscle biopsy for malignant hyperpyrexia (10 basic units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 21955	INITIATION OF MANAGEMENT OF ANAESTHESIA for electroencephalography (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21959	INITIATION OF MANAGEMENT OF ANAESTHESIA for brain stem evoked response audiometry (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21962	INITIATION OF MANAGEMENT OF ANAESTHESIA for electrocochleography by extratympanic method or transtympanic membrane insertion method (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21965	INITIATION OF MANAGEMENT OF ANAESTHESIA as a therapeutic procedure where it can be demonstrated that there is a clinical need for anaesthesia (5 basic units) <i>(See para T10.10 of explanatory notes to this Category)</i> Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21969	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is not confined in the chamber (including the administration of oxygen) (8 basic units) Fee: \$132.00	Benefit: 75% = \$99.00	85% = \$112.20
+ 21970	INITIATION OF MANAGEMENT OF ANAESTHESIA during hyperbaric therapy where the medical practitioner is confined in the chamber (including the administration of oxygen) (15 basic units) Fee: \$247.50	Benefit: 75% = \$185.65	85% = \$210.40
+ 21973	INITIATION OF MANAGEMENT OF ANAESTHESIA for brachytherapy using radioactive sealed sources (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21976	INITIATION OF MANAGEMENT OF ANAESTHESIA for therapeutic nuclear medicine (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15
+ 21980	INITIATION OF MANAGEMENT OF ANAESTHESIA for radiotherapy (5 basic units) Fee: \$82.50	Benefit: 75% = \$61.90	85% = \$70.15

		SUBGROUP 18 - MISCELLANEOUS		
+	21990	INITIATION OF MANAGEMENT OF ANAESTHESIA when no procedure ensues (3 basic units) <i>(See para T10.11 of explanatory notes to this Category)</i> Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10		
+	21992	INITIATION OF MANAGEMENT OF ANAESTHESIA performed on a person under the age of 10 years in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic (4 basic units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+	21997	INITIATION OF MANAGEMENT OF ANAESTHESIA in connection with a procedure covered by an item which has not been identified as attracting an anaesthetic rebate, not being a service to which item 21992 or 21965 applies where it can be demonstrated that there is a clinical need for anaesthesia (4 basic units) <i>(See para T10.12 of explanatory notes to this Category)</i> Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
		SUBGROUP 19 - THERAPEUTIC AND DIAGNOSTIC SERVICES		
+	22001	COLLECTION OF BLOOD FOR AUTOLOGOUS TRANSFUSION or when homologous blood is required for immediate transfusion in an emergency situation, when performed in association with the administration of anaesthesia (3 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10		
+	22002	ADMINISTRATION OF BLOOD or bone marrow already collected when performed in association with the administration of anaesthesia (4 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+	22007	AWAKE ENDOTRACHEAL INTUBATION with flexible fiberoptic scope associated with difficult airway when performed in association with the administration of anaesthesia (4 units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+	22008	DOUBLE LUMEN ENDOBRONCHIAL TUBE OR BRONCHIAL BLOCKER , insertion of when performed in association with the administration of anaesthesia (4 units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+	22012	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) when performed in association with the administration of anaesthesia (3 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10		
+	22014	BLOOD PRESSURE MONITORING (central venous, pulmonary arterial, systemic arterial or cardiac intracavity), by indwelling catheter - for each type of pressure up to a maximum of 4 pressures (not being a service to which item 13876 applies) when performed in association with the administration of anaesthesia relating to another discrete operation on the same day (3 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10		
+	22015	RIGHT HEART BALLOON CATHETER , insertion of, including pulmonary wedge pressure and cardiac output measurement, when performed in association with the administration of anaesthesia (6 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15		
+	22020	CENTRAL VEIN CATHETERISATION (via jugular, subclavian or femoral vein) by percutaneous or open exposure, not being a service to which item 13318 applies, when performed in association with the administration of anaesthesia (4 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+	22025	INTRAARTERIAL CANNULATION when performed in association with the administration of anaesthesia (4 units) <i>(See para T10.7 of explanatory notes to this Category)</i> Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10		
+	22030	INTRODUCTION OF A NARCOTIC , for the control of postoperative pain, into the epidural or intrathecal space in conjunction with an operation (2 units) <i>(See para T10.16 and T10.18 of explanatory notes to this Category)</i> Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05		

RELATIVE VALUE GUIDE		ANAESTHESIA FOR DENTAL
+ 22035	<p>INTRODUCTION OF A LOCAL ANAESTHETIC, for control of postoperative pain, into the epidural or intrathecal space, in conjunction with an operation (2 units) (See para T10.16 and T10.19 of explanatory notes to this Category)</p> <p>Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>	
+ 22040	<p>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 (2 units) (See para T10.16 and T10.20 of explanatory notes to this Category)</p> <p>Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>	
+ 22045	<p>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 (3 units) (See para T10.16 and T10.20 of explanatory notes to this Category)</p> <p>Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10</p>	
+ 22050	<p>INTRODUCTION OF A REGIONAL OF FIELD NERVE BLOCK peri-operatively performed in the induction room, theatre or recovery room for the control of post operative pain via the brachial plexus in conjunction with shoulder surgery (2 units) (See para T10.16 and T10.20 of explanatory notes to this Category)</p> <p>Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>	
+ 22055	<p>PERFUSION OF LIMB OR ORGAN using heart-lung machine or equivalent (12 units)</p> <p>Fee: \$198.00 Benefit: 75% = \$148.50 85% = \$168.30</p>	
+ 22060	<p>WHOLE BODY PERFUSION, CARDIAC BYPASS, using heart-lung machine or equivalent (20 units) (See para T10.9 of explanatory notes to this Category)</p> <p>Fee: \$330.00 Benefit: 75% = \$247.50 85% = \$280.50</p>	
+ 22065	<p>INDUCED CONTROLLED HYPOTHERMIA total body (5 units) (See para T10.9 of explanatory notes to this Category)</p> <p>Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15</p>	
+ 22070	<p>CARDIOPLEGIA, blood or crystalloid, administration by any route (10 units) (See para T10.9 of explanatory notes to this Category)</p> <p>Fee: \$165.00 Benefit: 75% = \$123.75 85% = \$140.25</p>	
+ 22075	<p>DEEP HYPOTHERMIC CIRCULATORY ARREST, with core temperature less than 22°C, including management of retrograde cerebral perfusion if performed (15 units) (See para T10.9 of explanatory notes to this Category)</p> <p>Fee: \$247.50 Benefit: 75% = \$185.65 85% = \$210.40</p>	
SUBGROUP 20 - ADMINISTRATION OF ANAESTHESIA IN CONNECTION WITH A DENTAL SERVICE		
+ 22900	<p>INITIATION OF MANAGEMENT BY A MEDICAL PRACTITIONER OF ANAESTHESIA for extraction of tooth or teeth with or without incision of soft tissue or removal of bone (5 basic units) (See para T10.13 of explanatory notes to this Category)</p> <p>Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15</p>	
+ 22905	<p>INITIATION OF MANAGEMENT OF ANAESTHESIA for restorative dental work (5 basic units) (See para T10.13 of explanatory notes to this Category)</p> <p>Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15</p>	
SUBGROUP 21 - ANAESTHESIA/PERFUSION TIME UNITS		
+ 23010	<p>ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA (a) administration of anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905; or (b) perfusion performed in association with item 22060; or (c) for assistance at anaesthesia performed in association with items 25200 to 25205</p> <p>For a period of: (FIFTEEN MINUTES OR LESS) (See para T10.3 of explanatory notes to this Category)</p> <p>Fee: \$16.50 Benefit: 75% = \$12.40 85% = \$14.05</p>	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
+ 23021	16 MINUTES TO 20 MINUTES (2 units) Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05	
+ 23022	21 MINUTES TO 25 MINUTES (2 units) Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05	
+ 23023	26 MINUTES TO 30 MINUTES (2 units) Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05	
+ 23031	31 MINUTES TO 35 MINUTES (3 units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 23032	36 MINUTES TO 40 MINUTES (3 units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 23033	41 MINUTES TO 45 MINUTES (3 units) Fee: \$49.50 Benefit: 75% = \$37.15 85% = \$42.10	
+ 23041	46 MINUTES TO 50 MINUTES (4 units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 23042	51 MINUTES TO 55 MINUTES (4 units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 23043	56 MINUTES TO 1:00 HOUR (4 units) Fee: \$66.00 Benefit: 75% = \$49.50 85% = \$56.10	
+ 23051	1:01 HOURS TO 1:05 HOURS (5 units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 23052	1:06 HOURS TO 1:10 HOURS (5 units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 23053	1:11 HOURS TO 1:15 HOURS (5 units) Fee: \$82.50 Benefit: 75% = \$61.90 85% = \$70.15	
+ 23061	1:16 HOURS TO 1:20 HOURS (6 units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 23062	1:21 HOURS TO 1:25 HOURS (6 units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 23063	1:26 HOURS TO 1:30 HOURS (6 units) Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15	
+ 23071	1:31 HOURS TO 1:35 HOURS (7 units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 23072	1:36 HOURS TO 1:40 HOURS (7 units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 23073	1:41 HOURS TO 1:45 HOURS (7 units) Fee: \$115.50 Benefit: 75% = \$86.65 85% = \$98.20	
+ 23081	1:46 HOURS TO 1:50 HOURS (8 units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 23082	1:51 HOURS TO 1:55 HOURS (8 units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 23083	1:56 HOURS TO 2:00 HOURS (8 units) Fee: \$132.00 Benefit: 75% = \$99.00 85% = \$112.20	
+ 23090	2:01 HOURS TO 2:15 HOURS (9 units) Fee: \$148.50 Benefit: 75% = \$111.40 85% = \$126.25	

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS	
+ 23100	2:16 HOURS TO 2:30 HOURS (10 units) Fee: \$165.00	Benefit: 75% = \$123.75	85% = \$140.25
+ 23110	2:31 HOURS TO 2:45 HOURS (11 units) Fee: \$181.50	Benefit: 75% = \$136.15	85% = \$154.30
+ 23120	2:46 HOURS TO 3:00 HOURS (12 units) Fee: \$198.00	Benefit: 75% = \$148.50	85% = \$168.30
+ 23130	3:01 HOURS TO 3:15 HOURS (13 units) Fee: \$214.50	Benefit: 75% = \$160.90	85% = \$182.35
+ 23140	3:16 HOURS TO 3:30 HOURS (14 units) Fee: \$231.00	Benefit: 75% = \$173.25	85% = \$196.35
+ 23150	3:31 HOURS TO 3:45 HOURS (15 units) Fee: \$247.50	Benefit: 75% = \$185.65	85% = \$210.40
+ 23160	3:46 HOURS TO 4:00 HOURS (16 units) Fee: \$264.00	Benefit: 75% = \$198.00	85% = \$224.40
+ 23170	4:01 HOURS TO 4:10 HOURS (17 units) Fee: \$280.50	Benefit: 75% = \$210.40	85% = \$238.45
+ 23180	4:11 HOURS TO 4:20 HOURS (18 units) Fee: \$297.00	Benefit: 75% = \$222.75	85% = \$252.45
+ 23190	4:21 HOURS TO 4:30 HOURS (19 units) Fee: \$313.50	Benefit: 75% = \$235.15	85% = \$266.50
+ 23200	4:31 HOURS TO 4:40 HOURS (20 units) Fee: \$330.00	Benefit: 75% = \$247.50	85% = \$280.50
+ 23210	4:41 HOURS TO 4:50 HOURS (21 units) Fee: \$346.50	Benefit: 75% = \$259.90	85% = \$294.55
+ 23220	4:51 HOURS TO 5:00 HOURS (22 units) Fee: \$363.00	Benefit: 75% = \$272.25	85% = \$308.55
+ 23230	5:01 HOURS TO 5:10 HOURS (23 units) Fee: \$379.50	Benefit: 75% = \$284.65	85% = \$322.60
+ 23240	5:11 HOURS TO 5:20 HOURS (24 units) Fee: \$396.00	Benefit: 75% = \$297.00	85% = \$338.90
+ 23250	5:21 HOURS TO 5:30 HOURS (25 units) Fee: \$412.50	Benefit: 75% = \$309.40	85% = \$355.40
+ 23260	5:31 HOURS TO 5:40 HOURS (26 units) Fee: \$429.00	Benefit: 75% = \$321.75	85% = \$371.90
+ 23270	5:41 HOURS TO 5:50 HOURS (27 units) Fee: \$445.50	Benefit: 75% = \$334.15	85% = \$388.40
+ 23280	(5:51 HOURS TO 6:00 HOURS (28 units) Fee: \$462.00	Benefit: 75% = \$346.50	85% = \$404.90
+ 23290	6:01 HOURS TO 6:10 HOURS (29 units) Fee: \$478.50	Benefit: 75% = \$358.90	85% = \$421.40
+ 23300	6:11 HOURS TO 6:20 HOURS (30 units) Fee: \$495.00	Benefit: 75% = \$371.25	85% = \$437.90
+ 23310	6:21 HOURS TO 6:30 HOURS (31 units) Fee: \$511.50	Benefit: 75% = \$383.65	85% = \$454.40

RELATIVE VALUE GUIDE

ANAESTHESIA TIME UNITS

+ 23320	6:31 HOURS TO 6:40 HOURS (32 units) Fee: \$528.00	Benefit: 75% = \$396.00	85% = \$470.90
+ 23330	6:41 HOURS TO 6:50 HOURS (33 units) Fee: \$544.50	Benefit: 75% = \$408.40	85% = \$487.40
+ 23340	6:51 HOURS TO 7:00 HOURS (34 units) Fee: \$561.00	Benefit: 75% = \$420.75	85% = \$503.90
+ 23350	7:01 HOURS TO 7:10 HOURS (35 units) Fee: \$577.50	Benefit: 75% = \$433.15	85% = \$520.40
+ 23360	7:11 HOURS TO 7:20 HOURS (36 units) Fee: \$594.00	Benefit: 75% = \$445.50	85% = \$536.90
+ 23370	7:21 HOURS TO 7:30 HOURS (37 units) Fee: \$610.50	Benefit: 75% = \$457.90	85% = \$553.40
+ 23380	7:31 HOURS TO 7:40 HOURS (38 units) Fee: \$627.00	Benefit: 75% = \$470.25	85% = \$569.90
+ 23390	7:41 HOURS TO 7:50 HOURS (39 units) Fee: \$643.50	Benefit: 75% = \$482.65	85% = \$586.40
+ 23400	7:51 HOURS TO 8:00 HOURS (40 units) Fee: \$660.00	Benefit: 75% = \$495.00	85% = \$602.90
+ 23410	8:01 HOURS TO 8:10 HOURS (41 units) Fee: \$676.50	Benefit: 75% = \$507.40	85% = \$619.40
+ 23420	8:11 HOURS TO 8:20 HOURS (42 units) Fee: \$693.00	Benefit: 75% = \$519.75	85% = \$635.90
+ 23430	8:21 HOURS TO 8:30 HOURS (43 units) Fee: \$709.50	Benefit: 75% = \$532.15	85% = \$652.40
+ 23440	8:31 HOURS TO 8:40 HOURS (44 units) Fee: \$726.00	Benefit: 75% = \$544.50	85% = \$668.90
+ 23450	8:41 HOURS TO 8:50 HOURS (45 units) Fee: \$742.50	Benefit: 75% = \$556.90	85% = \$685.40
+ 23460	8:51 HOURS TO 9:00 HOURS (46 units) Fee: \$759.00	Benefit: 75% = \$569.25	85% = \$701.90
+ 23470	9:01 HOURS TO 9:10 HOURS (47 units) Fee: \$775.50	Benefit: 75% = \$581.65	85% = \$718.40
+ 23480	9:11 HOURS TO 9:20 HOURS (48 units) Fee: \$792.00	Benefit: 75% = \$594.00	85% = \$734.90
+ 23490	9:21 HOURS TO 9:30 HOURS (49 units) Fee: \$808.50	Benefit: 75% = \$606.40	85% = \$751.40
+ 23500	9:31 HOURS TO 9:40 HOURS (50 units) Fee: \$825.00	Benefit: 75% = \$618.75	85% = \$767.90
+ 23510	9:41 HOURS TO 9:50 HOURS (51 units) Fee: \$841.50	Benefit: 75% = \$631.15	85% = \$784.40
+ 23520	9:51 HOURS TO 10:00 HOURS (52 units) Fee: \$858.00	Benefit: 75% = \$643.50	85% = \$800.90
+ 23530	10:01 HOURS TO 10:10 HOURS (53 units) Fee: \$874.50	Benefit: 75% = \$655.90	85% = \$817.40

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS	
+ 23540	10:11 HOURS TO 10:20 HOURS (54 units) Fee: \$891.00	Benefit: 75% = \$668.25	85% = \$833.90
+ 23550	10:21 HOURS TO 10:30 HOURS (55 units) Fee: \$907.50	Benefit: 75% = \$680.65	85% = \$850.40
+ 23560	10:31 HOURS TO 10:40 HOURS (56 units) Fee: \$924.00	Benefit: 75% = \$693.00	85% = \$866.90
+ 23570	10:41 HOURS TO 10:50 HOURS (57 units) Fee: \$940.50	Benefit: 75% = \$705.40	85% = \$883.40
+ 23580	10:51 HOURS TO 11:00 HOURS (58 units) Fee: \$957.00	Benefit: 75% = \$717.75	85% = \$899.90
+ 23590	11:01 HOURS TO 11:10 HOURS (59 units) Fee: \$973.50	Benefit: 75% = \$730.15	85% = \$916.40
+ 23600	11:11 HOURS TO 11:20 HOURS (60 units) Fee: \$990.00	Benefit: 75% = \$742.50	85% = \$932.90
+ 23610	11:21 HOURS TO 11:30 HOURS (61 units) Fee: \$1,006.50	Benefit: 75% = \$754.90	85% = \$949.40
+ 23620	11:31 HOURS TO 11:40 HOURS (62 units) Fee: \$1,023.00	Benefit: 75% = \$767.25	85% = \$965.90
+ 23630	11:41 HOURS TO 11:50 HOURS (63 units) Fee: \$1,039.50	Benefit: 75% = \$779.65	85% = \$982.40
+ 23640	11:51 HOURS TO 12:00 HOURS (64 units) Fee: \$1,056.00	Benefit: 75% = \$792.00	85% = \$998.90
+ 23650	12:01 HOURS TO 12:10 HOURS (65 units) Fee: \$1,072.50	Benefit: 75% = \$804.40	85% = \$1,015.40
+ 23660	12:11 HOURS TO 12:20 HOURS (66 units) Fee: \$1,089.00	Benefit: 75% = \$816.75	85% = \$1,031.90
+ 23670	12:21 HOURS TO 12:30 HOURS (67 units) Fee: \$1,105.50	Benefit: 75% = \$829.15	85% = \$1,048.40
+ 23680	12:31 HOURS TO 12:40 HOURS (68 units) Fee: \$1,122.00	Benefit: 75% = \$841.50	85% = \$1,064.90
+ 23690	12:41 HOURS TO 12:50 HOURS (69 units) Fee: \$1,138.50	Benefit: 75% = \$853.90	85% = \$1,081.40
+ 23700	12:51 HOURS TO 13:00 HOURS (70 units) Fee: \$1,155.00	Benefit: 75% = \$866.25	85% = \$1,097.90
+ 23710	13:01 HOURS TO 13:10 HOURS (71 units) Fee: \$1,171.50	Benefit: 75% = \$878.65	85% = \$1,114.40
+ 23720	13:11 HOURS TO 13:20 HOURS (72 units) Fee: \$1,188.00	Benefit: 75% = \$891.00	85% = \$1,130.90
+ 23730	13:21 HOURS TO 13:30 HOURS (73 units) Fee: \$1,204.50	Benefit: 75% = \$903.40	85% = \$1,147.40
+ 23740	13:31 HOURS TO 13:40 HOURS (74 units) Fee: \$1,221.00	Benefit: 75% = \$915.75	85% = \$1,163.90
+ 23750	13:41 HOURS TO 13:50 HOURS (75 units) Fee: \$1,237.50	Benefit: 75% = \$928.15	85% = \$1,180.40

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS	
+ 23760	13:51 HOURS TO 14:00 HOURS (76 units) Fee: \$1,254.00	Benefit: 75% = \$940.50	85% = \$1,196.90
+ 23770	14:01 HOURS TO 14:10 HOURS (77 units) Fee: \$1,270.50	Benefit: 75% = \$952.90	85% = \$1,213.40
+ 23780	14:11 HOURS TO 14:20 HOURS (78 units) Fee: \$1,287.00	Benefit: 75% = \$965.25	85% = \$1,229.90
+ 23790	14:21 HOURS TO 14:30 HOURS (79 units) Fee: \$1,303.50	Benefit: 75% = \$977.65	85% = \$1,246.40
+ 23800	14:31 HOURS TO 14:40 HOURS (80 units) Fee: \$1,320.00	Benefit: 75% = \$990.00	85% = \$1,262.90
+ 23810	14:41 HOURS TO 14:50 HOURS (81 units) Fee: \$1,336.50	Benefit: 75% = \$1,002.40	85% = \$1,279.40
+ 23820	14:51 HOURS TO 15:00 HOURS (82 units) Fee: \$1,353.00	Benefit: 75% = \$1,014.75	85% = \$1,295.90
+ 23830	15:01 HOURS TO 15:10 HOURS (83 units) Fee: \$1,369.50	Benefit: 75% = \$1,027.15	85% = \$1,312.40
+ 23840	15:11 HOURS TO 15:20 HOURS (84 units) Fee: \$1,386.00	Benefit: 75% = \$1,039.50	85% = \$1,328.90
+ 23850	15:21 HOURS TO 15:30 HOURS (85 units) Fee: \$1,402.50	Benefit: 75% = \$1,051.90	85% = \$1,345.40
+ 23860	15:31 HOURS TO 15:40 HOURS (86 units) Fee: \$1,419.00	Benefit: 75% = \$1,064.25	85% = \$1,361.90
+ 23870	15:41 HOURS TO 15:50 HOURS (87 units) Fee: \$1,435.50	Benefit: 75% = \$1,076.65	85% = \$1,378.40
+ 23880	15:51 HOURS TO 16:00 HOURS (88 units) Fee: \$1,452.00	Benefit: 75% = \$1,089.00	85% = \$1,394.90
+ 23890	16:01 HOURS TO 16:10 HOURS (89 units) Fee: \$1,468.50	Benefit: 75% = \$1,101.40	85% = \$1,411.40
+ 23900	16:11 HOURS TO 16:20 HOURS (90 units) Fee: \$1,485.00	Benefit: 75% = \$1,113.75	85% = \$1,427.90
+ 23910	16:21 HOURS TO 16:30 HOURS (91 units) Fee: \$1,501.50	Benefit: 75% = \$1,126.15	85% = \$1,444.40
+ 23920	16:31 HOURS TO 16:40 HOURS (92 units) Fee: \$1,518.00	Benefit: 75% = \$1,138.50	85% = \$1,460.90
+ 23930	16:41 HOURS TO 16:50 HOURS (93 units) Fee: \$1,534.50	Benefit: 75% = \$1,150.90	85% = \$1,477.40
+ 23940	16:51 HOURS TO 17:00 HOURS (94 units) Fee: \$1,551.00	Benefit: 75% = \$1,163.25	85% = \$1,493.90
+ 23950	17:01 HOURS TO 17:10 HOURS (95 units) Fee: \$1,567.50	Benefit: 75% = \$1,175.65	85% = \$1,510.40
+ 23960	17:11 HOURS TO 17:20 HOURS (96 units) Fee: \$1,584.00	Benefit: 75% = \$1,188.00	85% = \$1,526.90
+ 23970	17:21 HOURS TO 17:30 HOURS (97 units) Fee: \$1,600.50	Benefit: 75% = \$1,200.40	85% = \$1,543.40

RELATIVE VALUE GUIDE		ANAESTHESIA TIME UNITS
+ 23980	17:31 HOURS TO 17:40 HOURS (98 units) Fee: \$1,617.00 Benefit: 75% = \$1,212.75 85% = \$1,559.90	
+ 23990	17:41 HOURS TO 17:50 HOURS (99 units) Fee: \$1,633.50 Benefit: 75% = \$1,225.15 85% = \$1,576.40	
+ 24100	17:51 HOURS TO 18:00 HOURS (100 units) Fee: \$1,650.00 Benefit: 75% = \$1,237.50 85% = \$1,592.90	
+ 24101	18:01 HOURS TO 18:10 HOURS (101 units) Fee: \$1,666.50 Benefit: 75% = \$1,249.90 85% = \$1,609.40	
+ 24102	18:11 HOURS TO 18:20 HOURS (102 units) Fee: \$1,683.00 Benefit: 75% = \$1,262.25 85% = \$1,625.90	
+ 24103	18:21 HOURS TO 18:30 HOURS (103 units) Fee: \$1,699.50 Benefit: 75% = \$1,274.65 85% = \$1,642.40	
+ 24104	18:31 HOURS TO 18:40 HOURS (104 units) Fee: \$1,716.00 Benefit: 75% = \$1,287.00 85% = \$1,658.90	
+ 24105	18:41 HOURS TO 18:50 HOURS (105 units) Fee: \$1,732.50 Benefit: 75% = \$1,299.40 85% = \$1,675.40	
+ 24106	18:51 HOURS TO 19:00 HOURS (106 units) Fee: \$1,749.00 Benefit: 75% = \$1,311.75 85% = \$1,691.90	
+ 24107	19:01 HOURS TO 19:10 HOURS (107 units) Fee: \$1,765.50 Benefit: 75% = \$1,324.15 85% = \$1,708.40	
+ 24108	19:11 HOURS TO 19:20 HOURS (108 units) Fee: \$1,782.00 Benefit: 75% = \$1,336.50 85% = \$1,724.90	
+ 24109	19:21 HOURS TO 19:30 HOURS (109 units) Fee: \$1,798.50 Benefit: 75% = \$1,348.90 85% = \$1,741.40	
+ 24110	19:31 HOURS TO 19:40 HOURS (110 units) Fee: \$1,815.00 Benefit: 75% = \$1,361.25 85% = \$1,757.90	
+ 24111	19:41 HOURS TO 19:50 HOURS (111 units) Fee: \$1,831.50 Benefit: 75% = \$1,373.65 85% = \$1,774.40	
+ 24112	19:51 HOURS TO 20:00 HOURS (112 units) Fee: \$1,848.00 Benefit: 75% = \$1,386.00 85% = \$1,790.90	
+ 24113	20:01 HOURS TO 20:10 HOURS (113 units) Fee: \$1,864.50 Benefit: 75% = \$1,398.40 85% = \$1,807.40	
+ 24114	20:11 HOURS TO 20:20 HOURS (114 units) Fee: \$1,881.00 Benefit: 75% = \$1,410.75 85% = \$1,823.90	
+ 24115	20:21 HOURS TO 20:30 HOURS (115 units) Fee: \$1,897.50 Benefit: 75% = \$1,423.15 85% = \$1,840.40	
+ 24116	20:31 HOURS TO 20:40 HOURS (116 units) Fee: \$1,914.00 Benefit: 75% = \$1,435.50 85% = \$1,856.90	
+ 24117	20:41 HOURS TO 20:50 HOURS (117 units) Fee: \$1,930.50 Benefit: 75% = \$1,447.90 85% = \$1,873.40	
+ 24118	20:51 HOURS TO 21:00 HOURS (118 units) Fee: \$1,947.00 Benefit: 75% = \$1,460.25 85% = \$1,889.90	
+ 24119	21:01 HOURS TO 21:10 HOURS (119 units) Fee: \$1,963.50 Benefit: 75% = \$1,472.65 85% = \$1,906.40	

RELATIVE VALUE GUIDE		ANAESTHESIA MODIFYING UNITS	
+ 24120	21:11 HOURS TO 21:20 HOURS (120 units) Fee: \$1,980.00	Benefit: 75% = \$1,485.00	85% = \$1,922.90
+ 24121	21:21 HOURS TO 21:30 HOURS (121 units) Fee: \$1,996.50	Benefit: 75% = \$1,497.40	85% = \$1,939.40
+ 24122	21:31 HOURS TO 21:40 HOURS (122 units) Fee: \$2,013.00	Benefit: 75% = \$1,509.75	85% = \$1,955.90
+ 24123	21:41 HOURS TO 21:50 HOURS (123 units) Fee: \$2,029.50	Benefit: 75% = \$1,522.15	85% = \$1,972.40
+ 24124	21:51 HOURS TO 22:00 HOURS (124 units) Fee: \$2,046.00	Benefit: 75% = \$1,534.50	85% = \$1,988.90
+ 24125	22:01 HOURS TO 22:10 HOURS (125 units) Fee: \$2,062.50	Benefit: 75% = \$1,546.90	85% = \$2,005.40
+ 24126	22:11 HOURS TO 22:20 HOURS (126 units) Fee: \$2,079.00	Benefit: 75% = \$1,559.25	85% = \$2,021.90
+ 24127	22:21 HOURS TO 22:30 HOURS (127 units) Fee: \$2,095.50	Benefit: 75% = \$1,571.65	85% = \$2,038.40
+ 24128	22:31 HOURS TO 22:40 HOURS (128 units) Fee: \$2,112.00	Benefit: 75% = \$1,584.00	85% = \$2,054.90
+ 24129	22:41 HOURS TO 22:50 HOURS (129 units) Fee: \$2,128.50	Benefit: 75% = \$1,596.40	85% = \$2,071.40
+ 24130	22:51 HOURS TO 23:00 HOURS (130 units) Fee: \$2,145.00	Benefit: 75% = \$1,608.75	85% = \$2,087.90
+ 24131	23:01 HOURS TO 23:10 HOURS (131 units) Fee: \$2,161.50	Benefit: 75% = \$1,621.15	85% = \$2,104.40
+ 24132	23:11 HOURS TO 23:20 HOURS (132 units) Fee: \$2,178.00	Benefit: 75% = \$1,633.50	85% = \$2,120.90
+ 24133	23:21 HOURS TO 23:30 HOURS (133 units) Fee: \$2,194.50	Benefit: 75% = \$1,645.90	85% = \$2,137.40
+ 24134	23:31 HOURS TO 23:40 HOURS (134 units) Fee: \$2,211.00	Benefit: 75% = \$1,658.25	85% = \$2,153.90
+ 24135	23:41 HOURS TO 23:50 HOURS (135 units) Fee: \$2,227.50	Benefit: 75% = \$1,670.65	85% = \$2,170.40
+ 24136	23:51 HOURS TO 24:00 HOURS (136 units) Fee: \$2,244.00	Benefit: 75% = \$1,683.00	85% = \$2,186.90
SUBGROUP 22 - ANAESTHESIA/PERFUSION MODIFYING UNITS - PHYSICAL STATUS			
ANAESTHESIA, PERFUSION or ASSISTANCE AT ANAESTHESIA			
(a) for anaesthesia performed in association with an item in the range 20100 to 21997 or 22900 to 22905 ; or (b) for perfusion performed in association with item 22060 ; or			
(c) for assistance at anaesthesia performed in association with items 25200 to 25205			
Where the patient has severe systemic disease equivalent to ASA physical status indicator 3 (1 unit) (See para T10.3 of explanatory notes to this Category)			
+ 25000	Fee: \$16.50	Benefit: 75% = \$12.40	85% = \$14.05
Where the patient has severe systemic disease which is a constant threat to life equivalent to ASA physical status indicator 4 (2 units) (See para T10.3 of explanatory notes to this Category)			
+ 25005	Fee: \$33.00	Benefit: 75% = \$24.75	85% = \$28.05

RELATIVE VALUE GUIDE		ANAESTHESIA MODIFYING UNITS	
+ 25010	For a patient who is not expected to survive for 24 hours with or without the operation, equivalent to ASA physical status indicator 5 (3 units) (See para T10.3 of explanatory notes to this Category) Fee: \$49.50	Benefit: 75% = \$37.15	85% = \$42.10
SUBGROUP 23 - ANAESTHESIA/PERFUSION MODIFYING UNITS - OTHER			
+ 25015	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient is less than 12 months of age or 70 years or greater (1 unit) Fee: \$16.50	Benefit: 75% = \$12.40	85% = \$14.05
+ 25020	ANAESTHESIA, PERFUSION OR ASSISTANCE AT ANAESTHESIA - where the patient requires immediate treatment without which there would be significant threat to life or body part - not being a service associated with a service to which item 25025 or 25030 or 25050 applies (2 units) (See para T10.3 of explanatory notes to this Category) Fee: \$33.00	Benefit: 75% = \$24.75	85% = \$28.05
SUBGROUP 24 - ANAESTHESIA AFTER HOURS EMERGENCY MODIFIER			
25025	EMERGENCY ANAESTHESIA performed in the after hours period where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for the emergency anaesthesia service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020 , 25030 or 25050 applies (See para T10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of the fee for the anaesthetic service. That is: (a) an anaesthesia item/s in the range 20100 - 21997 or 22900 plus, (b) an item in the range 23010 - 24136 , plus (c) where applicable, an item in the range 25000 - 25015 , (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050		
25030	ASSISTANCE AT AFTER HOURS EMERGENCY ANAESTHESIA where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the time for which the assistant is in professional attendance on the patient is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020 , 25025 or 25050 applies (See para T10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of the fee for assistance at anaesthesia. That is: (a) an assistant anaesthesia item in the range 25200 - 25205 plus, (b) an item in the range 23010 - 24136 , plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050		
SUBGROUP 25 - PERFUSION AFTER HOURS EMERGENCY MODIFIER			
25050	AFTER HOURS EMERGENCY PERFUSION where the patient requires immediate treatment without which there would be significant threat to life or body part and where more than 50% of the perfusion service is provided in the after hours period, being the period from 8pm to 8am on any weekday, or at any time on a Saturday, a Sunday or a public holiday - not being a service associated with a service to which item 25020 , 25025 or 25030 applies (See para T10.3 of explanatory notes to this Category) Derived Fee: An additional amount of 50% of the fee for the perfusion service. That is: (a) item 22060 , plus (b) an item in the range 23010 - 24136 , plus (c) where applicable, an item in the range 25000 - 25015 plus, (d) where performed, any associated therapeutic or diagnostic service/s in the range 22001 - 22050 and 22065 - 22075		
SUBGROUP 26 - ASSISTANCE AT ANAESTHESIA			
+ 25200	ASSISTANCE IN THE ADMINISTRATION OF ANAESTHESIA on a patient in imminent danger of death requiring continuous life saving emergency treatment, to the exclusion of all other patients (5 basic units) (See para T10.8 of explanatory notes to this Category) Derived Fee: An amount of \$82.50 (5 basic units) plus an item in the range 23010 - 24136 plus, where applicable, an item in the range 25000 - 25020		

+ 25205	<p>ASSISTANCE IN THE ADMINISTRATION OF ELECTIVE ANAESTHESIA 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; or (v) where the anaesthesia time exceeds 6 hours and the assistance is provided to the exclusion of all other patients (5 basic units) (See para T10.8 of explanatory notes to this Category)</p> <p>Derived Fee: An amount of \$82.50 (5 Basic units), plus an item in the range 23010 - 24136, plus, where applicable, an item in the range 25000 - 25020</p>
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OPERATIONS	GENERAL
GROUP T8 - SURGICAL OPERATIONS	
SUBGROUP 1 - GENERAL	
30001	OPERATIVE PROCEDURE, not being a service to which any other item in this Group applies, being a service to which an item in this Group would have applied had the procedure not been discontinued on medical grounds <i>(See para T8.8 of explanatory notes to this Category)</i> Derived Fee: 50% of the fee which would have applied had the procedure not been discontinued
30003	LOCALISED BURNS, dressing of, (not involving grafting) each attendance at which the procedure is performed, including any associated consultation Fee: \$29.45 Benefit: 75% = \$22.10 85% = \$25.05
30006	EXTENSIVE BURNS, dressing of, without anaesthesia (not involving grafting) each attendance at which the procedure is performed, including any associated consultation Fee: \$37.70 Benefit: 75% = \$28.30 85% = \$32.05
30009 G 30010 S	LOCALISED BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) Fee: \$49.20 Benefit: 75% = \$36.90 85% = \$41.85 Fee: \$59.90 Benefit: 75% = \$44.95 85% = \$50.95
30013 G 30014 S	EXTENSIVE BURNS, dressing of, under general anaesthesia (not involving grafting) (Anaes.) Fee: \$106.10 Benefit: 75% = \$79.60 85% = \$90.20 Fee: \$126.00 Benefit: 75% = \$94.50 85% = \$107.10
30017	BURNS, excision of, under general anaesthesia, involving not more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70
30020	BURNS, excision of, under general anaesthesia, involving more than 10 per cent of body surface, where grafting is not carried out during the same operation (Anaes.) (Assist.) Fee: \$514.80 Benefit: 75% = \$386.10 85% = \$457.70
30023	WOUND OF SOFT TISSUE, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) <i>(See para T8.9 of explanatory notes to this Category)</i> Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70
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.) <i>(See para T8.9 of explanatory notes to this Category)</i> Fee: \$42.35 Benefit: 75% = \$31.80 85% = \$36.00
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.) <i>(See para T8.9 of explanatory notes to this Category)</i> Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05
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.) <i>(See para T8.9 of explanatory notes to this Category)</i> Fee: \$66.90 Benefit: 75% = \$50.20 85% = \$56.90
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.) <i>(See para T8.9 of explanatory notes to this Category)</i> Fee: \$95.25 Benefit: 75% = \$71.45 85% = \$81.00
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.) <i>(See para T8.9 of explanatory notes to this Category)</i> Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05

OPERATIONS		GENERAL	
	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.) (See para T8.9 of explanatory notes to this Category)		
30041 G	Fee: \$116.80	Benefit: 75% = \$87.60	85% = \$99.30
30042 S	Fee: \$150.55	Benefit: 75% = \$112.95	85% = \$128.00
	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.) (See para T8.9 of explanatory notes to this Category)		
30045	Fee: \$95.25	Benefit: 75% = \$71.45	85% = \$81.00
	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.) (See para T8.9 of explanatory notes to this Category)		
30048 G	Fee: \$121.40	Benefit: 75% = \$91.05	85% = \$103.20
30049 S	Fee: \$150.55	Benefit: 75% = \$112.95	85% = \$128.00
	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.)		
30052	Fee: \$205.90	Benefit: 75% = \$154.45	85% = \$175.05
	WOUNDS, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in this Group applies (Anaes.)		
30055	Fee: \$59.90	Benefit: 75% = \$44.95	85% = \$50.95
	POSTOPERATIVE HAEMORRHAGE, control of, under general anaesthesia, as an independent procedure (Anaes.)		
30058	Fee: \$116.80	Benefit: 75% = \$87.60	85% = \$99.30
	SUPERFICIAL FOREIGN BODY, REMOVAL OF, (including from cornea or sclera), as an independent procedure (Anaes.)		
30061	Fee: \$19.00	Benefit: 75% = \$14.25	85% = \$16.15
	SUBCUTANEOUS FOREIGN BODY, removal of, requiring incision and exploration, including closure of wound if performed, as an independent procedure (Anaes.)		
30064	Fee: \$89.10	Benefit: 75% = \$66.85	85% = \$75.75
	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, removal of, as an independent procedure (Anaes.) (Assist.)		
30067 G	Fee: \$181.30	Benefit: 75% = \$136.00	85% = \$154.15
30068 S	Fee: \$224.35	Benefit: 75% = \$168.30	85% = \$190.70
	BIOPSY OF SKIN OR MUCOUS MEMBRANE, as an independent procedure (Anaes.)		
30071	Fee: \$42.35	Benefit: 75% = \$31.80	85% = \$36.00
	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, as an independent procedure (Anaes.)		
30074 G	Fee: \$95.25	Benefit: 75% = \$71.45	85% = \$81.00
30075 S	Fee: \$121.40	Benefit: 75% = \$91.05	85% = \$103.20
	DRILL BIOPSY OF LYMPH GLAND, DEEP TISSUE OR ORGAN, as an independent procedure (Anaes.) (See para T8.10 of explanatory notes to this Category)		
30078	Fee: \$39.25	Benefit: 75% = \$29.45	85% = \$33.40
	BIOPSY OF BONE MARROW by trephine using open approach (Anaes.)		
30081	Fee: \$89.10	Benefit: 75% = \$66.85	85% = \$75.75
	BIOPSY OF BONE MARROW by trephine using percutaneous approach with a Jamshidi needle or similar device (Anaes.)		
30084	Fee: \$47.65	Benefit: 75% = \$35.75	85% = \$40.55
	BIOPSY OF BONE MARROW by aspiration or PUNCH BIOPSY OF SYNOVIAL MEMBRANE (Anaes.)		
30087	Fee: \$23.90	Benefit: 75% = \$17.95	85% = \$20.35
	BIOPSY OF PLEURA, PERCUTANEOUS 1 or more biopsies on any 1 occasion (Anaes.)		
30090	Fee: \$104.20	Benefit: 75% = \$78.15	85% = \$88.60
	NEEDLE BIOPSY OF VERTEBRA (Anaes.)		
30093	Fee: \$139.10	Benefit: 75% = \$104.35	85% = \$118.25

OPERATIONS		GENERAL	
30094	PERCUTANEOUS ASPIRATION BIOPSY of deep organ using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$153.55 Benefit: 75% = \$115.20 85% = \$130.55		
30096	SCALENE NODE BIOPSY (Anaes.) Fee: \$149.10 Benefit: 75% = \$111.85 85% = \$126.75		
30099	SINUS, excision of, involving superficial tissue only (Anaes.) Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05		
30102 G 30103 S	SINUS, excision of, involving muscle and deep tissue (Anaes.) Fee: \$121.40 Benefit: 75% = \$91.05 85% = \$103.20 Fee: \$149.10 Benefit: 75% = \$111.85 85% = \$126.75		
30104	PRE-AURICULAR SINUS, excision of (Anaes.) Fee: \$102.95 Benefit: 75% = \$77.25 85% = \$87.55		
30106 G 30107 S	GANGLION OR SMALL BURSA, excision of, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$126.00 Benefit: 75% = \$94.50 85% = \$107.10 Fee: \$178.30 Benefit: 75% = \$133.75 85% = \$151.60		
30110 G 30111 S	BURSA (LARGE), INCLUDING OLECRANON, CALCANEUM OR PATELLA, excision of (Anaes.) (Assist.) Fee: \$230.55 Benefit: 75% = \$172.95 85% = \$196.00 Fee: \$301.20 Benefit: 75% = \$225.90 85% = \$256.05		
30114	BURSA, SEMIMEMBRANOSUS (Baker's cyst), excision of (Anaes.) (Assist.) Fee: \$301.20 Benefit: 75% = \$225.90 85% = \$256.05		
30165	LIPECTOMY transverse wedge excision of abdominal apron (Anaes.) (Assist.) Fee: \$368.80 Benefit: 75% = \$276.60 85% = \$313.50		
30168	LIPECTOMY wedge excision of skin or fat not being a service to which item 30165 applies 1 EXCISION (Anaes.) (Assist.) Fee: \$368.80 Benefit: 75% = \$276.60 85% = \$313.50		
30171	LIPECTOMY wedge excision of skin or fat not being a service to which item 30165 applies 2 OR MORE EXCISIONS (Anaes.) (Assist.) <i>(See para T8.11 of explanatory notes to this Category)</i> Fee: \$560.95 Benefit: 75% = \$420.75 85% = \$503.85		
30174	LIPECTOMY subumbilical excision with undermining of skin edges and strengthening of musculoaponeurotic wall (Anaes.) (Assist.) Fee: \$560.95 Benefit: 75% = \$420.75 85% = \$503.85		
30177	LIPECTOMY radical abdominoplasty (Pitanguy type or similar) with excision of skin and subcutaneous tissue, repair of musculoaponeurotic layer and transposition of umbilicus (Anaes.) (Assist.) Fee: \$799.20 Benefit: 75% = \$599.40 85% = \$742.10		
30180	AXILLARY HYPERHIDROSIS, wedge excision for (Anaes.) Fee: \$110.65 Benefit: 75% = \$83.00 85% = \$94.10		
30183	AXILLARY HYPERHIDROSIS, total excision of sweat gland bearing area (Anaes.) Fee: \$199.80 Benefit: 75% = \$149.85 85% = \$169.85		
30186	PALMAR OR PLANTAR WARTS, removal of, not being a service to which item 30187 applies (Anaes.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$38.50 Benefit: 75% = \$28.90 85% = \$32.75		
30187	PALMAR OR PLANTAR WARTS, removal of, by carbon dioxide laser or erbium laser, requiring admission to a hospital or day-hospital facility, or when performed by a specialist in the practice of his/her specialty, (5 or more warts) (Anaes.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$208.35 Benefit: 75% = \$156.30 85% = \$177.10		

OPERATIONS		GENERAL
30189	<p>WARTS or MOLLUSCUM CONTAGIOSUM, removal of, by any method (other than by chemical means), where undertaken in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Group applies (Anaes.) (See para T8.12 of explanatory notes to this Category)</p> <p>Fee: \$119.40 Benefit: 75% = \$89.55 85% = \$101.50</p>	
30190	<p>ANGIOFIBROMAS, TRICHOEPITHELIOMAS or other severely disfiguring tumours suitable for laser excision as confirmed by specialist opinion, of the face or neck, removal of, by carbon dioxide laser or erbium laser excision-ablation including associated resurfacing (10 or more tumours) (Anaes.) (Assist.)</p> <p>Fee: \$322.50 Benefit: 75% = \$241.90 85% = \$274.15</p>	
30192	<p>PREMALIGNANT SKIN LESIONS, treatment of, by galvanocautery or electrodesiccation or cryocautery (10 or more lesions) (Anaes.) (See para T8.12 of explanatory notes to this Category)</p> <p>Fee: \$32.15 Benefit: 75% = \$24.15 85% = \$27.35</p>	
30195	<p>NEOPLASTIC SKIN LESIONS, other than viral verrucae (common warts) and seborrheic keratoses, treatment by electrosurgical destruction, simple curettage or shave excision, or laser photocoagulation, not being a service to which items 30196, 30197, 30202, 30203 or 30205 apply (1 or more lesions) (Anaes.)</p> <p>Fee: \$51.45 Benefit: 75% = \$38.60 85% = \$43.75</p>	
30196	<p>CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser or erbium laser excision-ablation, including any associated cryotherapy or diathermy, not being a service to which item 30197 applies (Anaes.) (See para T8.13 of explanatory notes to this Category)</p> <p>Fee: \$102.40 Benefit: 75% = \$76.80 85% = \$87.05</p>	
30197	<p>CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, by serial curettage or carbon dioxide laser excision-ablation, including any associated cryotherapy or diathermy, (10 or more lesions) (Anaes.) (See para T8.13 of explanatory notes to this Category)</p> <p>Fee: \$356.80 Benefit: 75% = \$267.60 85% = \$303.30</p>	
30202	<p>CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles, not being a service to which item 30203 applies (See para T8.13 of explanatory notes to this Category)</p> <p>Fee: \$39.15 Benefit: 75% = \$29.40 85% = \$33.30</p>	
30203	<p>CANCER OF SKIN OR MUCOUS MEMBRANE proven by histopathology or confirmed by specialist opinion, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles (10 OR MORE LESIONS) (See para T8.13 of explanatory notes to this Category)</p> <p>Fee: \$138.05 Benefit: 75% = \$103.55 85% = \$117.35</p>	
30205	<p>CANCER OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE CANCER EXTENDS INTO CARTILAGE (Anaes.)</p> <p>Fee: \$102.40 Benefit: 75% = \$76.80 85% = \$87.05</p>	
30207	<p>SKIN LESIONS, multiple injections with hydrocortisone or similar preparations (Anaes.)</p> <p>Fee: \$36.15 Benefit: 75% = \$27.15 85% = \$30.75</p>	
30210	<p>KELOID and other SKIN LESIONS, EXTENSIVE, MULTIPLE INJECTIONS OF HYDROCORTISONE or similar preparations where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.)</p> <p>Fee: \$132.15 Benefit: 75% = \$99.15 85% = \$112.35</p>	
30213	<p>TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - limited to a maximum of 6 sessions (including any sessions to which items 14100 to 14118 and 30213 apply) in any 12 month period - for a session of at least 20 minutes duration (Anaes.) (See para T8.14 of explanatory notes to this Category)</p> <p>Fee: \$89.00 Benefit: 75% = \$66.75 85% = \$75.65</p>	
30214	<p>TELANGIECTASES OR STARBURST VESSELS on the head or neck where lesions are visible from 4 metres, diathermy or sclerosant injection of, including associated consultation - session of at least 20 minutes duration - where it can be demonstrated that a 7th or subsequent session (including any sessions to which items 14100 to 14118 and 30213 apply) is indicated in a 12 month period (See para T8.14 of explanatory notes to this Category)</p> <p>Fee: \$89.00 Benefit: 75% = \$66.75 85% = \$75.65</p>	

OPERATIONS		GENERAL
30216	HAEMATOMA, aspiration of (Anaes.) Fee: \$22.15 Benefit: 75% = \$16.65 85% = \$18.85	
30219	HAEMATOMA, FURUNCLE, SMALL ABSCESS OR SIMILAR LESION not requiring admission to a hospital or day-hospital facility - INCISION WITH DRAINAGE OF (excluding aftercare) Fee: \$22.15 Benefit: 75% = \$16.65 85% = \$18.85	
30223	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) Fee: \$132.15 Benefit: 75% = \$99.15 85% = \$112.35	
30224	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$192.65 Benefit: 75% = \$144.50 85% = \$163.80	
30225	ABSCESS DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
30226	MUSCLE, excision of (LIMITED), or fasciotomy (Anaes.) Fee: \$121.40 Benefit: 75% = \$91.05 85% = \$103.20	
30229	MUSCLE, excision of (EXTENSIVE) (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	
30232	MUSCLE, RUPTURED, repair of (limited), not associated with external wound (Anaes.) Fee: \$181.30 Benefit: 75% = \$136.00 85% = \$154.15	
30235	MUSCLE, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
30238	FASCIA, DEEP, repair of, FOR HERNIATED MUSCLE (Anaes.) Fee: \$121.40 Benefit: 75% = \$91.05 85% = \$103.20	
30241	BONE TUMOUR, INNOCENT, excision of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
30244	STYLOID PROCESS OF TEMPORAL BONE, removal of (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
30246	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) Fee: \$559.25 Benefit: 75% = \$419.45 85% = \$502.15	
30247	PAROTID GLAND, total extirpation of (Anaes.) (Assist.) Fee: \$599.40 Benefit: 75% = \$449.55 85% = \$542.30	
30250	PAROTID GLAND, total extirpation of, with preservation of facial nerve (Anaes.) (Assist.) Fee: \$1,014.30 Benefit: 75% = \$760.75 85% = \$957.20	
30251	RECURRENT PAROTID TUMOUR, excision of, with preservation of facial nerve (Anaes.) (Assist.) Fee: \$1,558.05 Benefit: 75% = \$1,168.55 85% = \$1,500.95	
30253	PAROTID GLAND, SUPERFICIAL LOBECTOMY OF, with exposure of facial nerve (Anaes.) (Assist.) Fee: \$676.30 Benefit: 75% = \$507.25 85% = \$619.20	
30255	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) Fee: \$900.50 Benefit: 75% = \$675.40 85% = \$843.40	
30256	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00	
30259	SUBLINGUAL GLAND, extirpation of (Anaes.) Fee: \$159.80 Benefit: 75% = \$119.85 85% = \$135.85	
30262	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) Fee: \$47.65 Benefit: 75% = \$35.75 85% = \$40.55	

OPERATIONS		GENERAL
30265 G 30266 S	SALIVARY GLAND, removal of CALCULUS from duct or meatotomy or marsupialisation, 1 or more such procedures. (Anaes.) Fee: \$95.25 Benefit: 75% = \$71.45	85% = \$81.00 85% = \$103.20
30269	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) Fee: \$121.40 Benefit: 75% = \$91.05	85% = \$103.20
30272	TONGUE, partial excision of (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85	85% = \$203.80
30275	RADICAL EXCISION OF INTRAORAL TUMOUR INVOLVING RESECTION OF MANDIBLE AND LYMPH GLANDS OF NECK (commandotype operation) (Anaes.) (Assist.) Fee: \$1,429.25 Benefit: 75% = \$1,071.95	85% = \$1,372.15
30278	TONGUE TIE, repair of, not being a service to which another item in this Group applies (Anaes.) Fee: \$37.70 Benefit: 75% = \$28.30	85% = \$32.05
30281	TONGUE TIE, MANDIBULAR FRENULUM or MAXILLARY FRENULUM, repair of, in a person aged 2 years and over, under general anaesthesia (Anaes.) Fee: \$96.85 Benefit: 75% = \$72.65	85% = \$82.35
30282 G 30283 S	RANULA OR MUCOUS CYST OF MOUTH, removal of (Anaes.) Fee: \$126.00 Benefit: 75% = \$94.50	85% = \$107.10 85% = \$141.10
30286	BRANCHIAL CYST, removal of (Anaes.) (Assist.) Fee: \$322.60 Benefit: 75% = \$241.95	85% = \$274.25
30289	BRANCHIAL FISTULA, removal of (Anaes.) (Assist.) Fee: \$407.25 Benefit: 75% = \$305.45	85% = \$350.15
30293	CERVICAL OESOPHAGOSTOMY or CLOSURE OF CERVICAL OESOPHAGOSTOMY with or without plastic repair (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90	85% = \$307.00
30294	CERVICAL OESOPHAGECTOMY with tracheostomy and oesophagostomy, with or without plastic reconstruction; or LARYNGOPHARYNGECTOMY with tracheostomy and plastic reconstruction (Anaes.) (Assist.) Fee: \$1,429.25 Benefit: 75% = \$1,071.95	85% = \$1,372.15
30296	THYROIDECTOMY, total (Anaes.) (Assist.) Fee: \$830.05 Benefit: 75% = \$622.55	85% = \$772.95
30297	THYROIDECTOMY following previous thyroid surgery (Anaes.) (Assist.) Fee: \$830.05 Benefit: 75% = \$622.55	85% = \$772.95
30306	TOTAL HEMITHYROIDECTOMY (Anaes.) (Assist.) Fee: \$647.50 Benefit: 75% = \$485.65	85% = \$590.40
30308	BILATERAL SUBTOTAL THYROIDECTOMY (Anaes.) (Assist.) Fee: \$647.50 Benefit: 75% = \$485.65	85% = \$590.40
30309	THYROIDECTOMY, SUBTOTAL for THYROTOXICOSIS (Anaes.) (Assist.) Fee: \$830.05 Benefit: 75% = \$622.55	85% = \$772.95
30310	THYROID, unilateral subtotal thyroidectomy or equivalent partial thyroidectomy (Anaes.) (Assist.) Fee: \$370.85 Benefit: 75% = \$278.15	85% = \$315.25
30313	THYROGLOSSAL CYST, removal of (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00	85% = \$188.15
30314	THYROGLOSSAL CYST or FISTULA or both, radical removal of, including thyroglossal duct and portion of hyoid bone (Anaes.) (Assist.) Fee: \$370.85 Benefit: 75% = \$278.15	85% = \$315.25
30315	PARATHYROID operation for hyperparathyroidism (Anaes.) (Assist.) Fee: \$924.20 Benefit: 75% = \$693.15	85% = \$867.10

OPERATIONS		GENERAL	
30317	CERVICAL REEXPLORATION for recurrent or persistent hyperparathyroidism (Anaes.) (Assist.) Fee: \$1,106.70 Benefit: 75% = \$830.05 85% = \$1,049.60		
30318	MEDIASTINUM, exploration of, via the cervical route, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) Fee: \$735.85 Benefit: 75% = \$551.90 85% = \$678.75		
30320	MEDIASTINUM, exploration of, via mediastinotomy, for hyperparathyroidism (including thymectomy) (Anaes.) (Assist.) Fee: \$1,106.70 Benefit: 75% = \$830.05 85% = \$1,049.60		
30321	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of (Anaes.) (Assist.) Fee: \$735.85 Benefit: 75% = \$551.90 85% = \$678.75		
30323	RETROPERITONEAL NEUROENDOCRINE TUMOUR, removal of, requiring complex and extensive dissection (Anaes.) (Assist.) Fee: \$1,106.70 Benefit: 75% = \$830.05 85% = \$1,049.60		
30324	ADRENAL GLAND TUMOUR, excision of (Anaes.) (Assist.) Fee: \$1,106.70 Benefit: 75% = \$830.05 85% = \$1,049.60		
30329	LYMPH GLANDS of GROIN, limited excision of (Anaes.) Fee: \$200.20 Benefit: 75% = \$150.15 85% = \$170.20		
30330	LYMPH GLANDS of GROIN, radical excision of (Anaes.) (Assist.) Fee: \$582.75 Benefit: 75% = \$437.10 85% = \$525.65		
30332	LYMPH NODES of AXILLA, limited excision of (sampling) (Anaes.) (Assist.) Fee: \$281.15 Benefit: 75% = \$210.90 85% = \$239.00		
30335	LYMPH NODES of AXILLA, complete excision of, to level I (Anaes.) (Assist.) <i>(See para T8.15 of explanatory notes to this Category)</i> Fee: \$702.85 Benefit: 75% = \$527.15 85% = \$645.75		
30336	LYMPH NODES of AXILLA, complete excision of, to level II or level III (Anaes.) (Assist.) <i>(See para T8.15 of explanatory notes to this Category)</i> Fee: \$843.45 Benefit: 75% = \$632.60 85% = \$786.35		
30373	LAPAROTOMY (exploratory), including associated biopsies, where no other intra-abdominal procedure is performed (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70		
30375	LAPAROTOMY involving Caecostomy, Enterostomy, Colostomy, Enterotomy, Colotomy, Cholecystostomy, Gastrostomy, Gastrotomy, Reduction of intussusception, Removal of Meckel's diverticulum, Suture of perforated peptic ulcer, Simple repair of ruptured viscus, Reduction of volvulus, Pyloroplasty (adult) or Drainage of pancreas (Anaes.) (Assist.) <i>(See para T8.16 of explanatory notes to this Category)</i> Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50		
30376	LAPAROTOMY INVOLVING DIVISION OF PERITONEAL ADHESIONS (where no other intraabdominal procedure is performed) (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50		
30378	LAPAROTOMY involving division of adhesions in conjunction with another intraabdominal procedure where the time taken to divide the adhesions is between 45 minutes and 2 hours (Anaes.) (Assist.) Fee: \$424.55 Benefit: 75% = \$318.45 85% = \$367.45		
30379	LAPAROTOMY WITH DIVISION OF EXTENSIVE ADHESIONS (duration greater than 2 hours) with or without insertion of long intestinal tube (Anaes.) (Assist.) Fee: \$752.55 Benefit: 75% = \$564.45 85% = \$695.45		
30382	ENTEROCUTANEOUS FISTULA, radical repair of, involving extensive dissection and resection of bowel (Anaes.) (Assist.) Fee: \$1,059.60 Benefit: 75% = \$794.70 85% = \$1,002.50		
30384	LAPAROTOMY FOR GRADING OF LYMPHOMA, including splenectomy, liver biopsies, lymph node biopsies and oophoropexy (Anaes.) (Assist.) Fee: \$891.35 Benefit: 75% = \$668.55 85% = \$834.25		

OPERATIONS		GENERAL	
30385	LAPAROTOMY FOR CONTROL OF POSTOPERATIVE HAEMORRHAGE, where no other procedure is performed (Anaes.) (Assist.) Fee: \$456.70	Benefit: 75% = \$342.55	85% = \$399.60
30387	LAPAROTOMY INVOLVING OPERATION ON ABDOMINAL VISCERA (including pelvic viscera), not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$514.80	Benefit: 75% = \$386.10	85% = \$457.70
30388	LAPAROTOMY for trauma involving 3 or more organs (Anaes.) (Assist.) Fee: \$1,295.15	Benefit: 75% = \$971.40	85% = \$1,238.05
30390	LAPAROSCOPY, diagnostic (Anaes.) Fee: \$178.30	Benefit: 75% = \$133.75	85% = \$151.60
30391	LAPAROSCOPY with biopsy (Anaes.) (Assist.) Fee: \$230.55	Benefit: 75% = \$172.95	85% = \$196.00
30392	RADICAL OR DEBULKING OPERATION for advanced intra-abdominal malignancy, with or without omentectomy, as an independent procedure (Anaes.) (Assist.) Fee: \$546.90	Benefit: 75% = \$410.20	85% = \$489.80
30393	LAPAROSCOPIC DIVISION OF ADHESIONS in association with another intra-abdominal procedure where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) Fee: \$424.55	Benefit: 75% = \$318.45	85% = \$367.45
30394	LAPAROTOMY for drainage of subphrenic abscess, pelvic abscess, appendiceal abscess, ruptured appendix or for peritonitis from any cause, with or without appendicectomy (Anaes.) (Assist.) Fee: \$399.55	Benefit: 75% = \$299.70	85% = \$342.45
30396	LAPAROTOMY for gross intra peritoneal sepsis requiring debridement of fibrin, with or without removal of foreign material or enteric contents, with lavage of the entire peritoneal cavity via a major abdominal incision, with or without closure of abdomen and with or without mesh or zipper insertion (Anaes.) (Assist.) Fee: \$824.20	Benefit: 75% = \$618.15	85% = \$767.10
30397	LAPAROSTOMY, via wound previously made and left open or closed with zipper, involving change of dressings or packs, and with or without drainage of loculated collections (Anaes.) Fee: \$188.40	Benefit: 75% = \$141.30	85% = \$160.15
30399	LAPAROSTOMY, final closure of wound made at previous operation, after removal of dressings or packs and removal of mesh or zipper if previously inserted (Anaes.) (Assist.) Fee: \$259.10	Benefit: 75% = \$194.35	85% = \$220.25
30400	LAPAROTOMY WITH INSERTION OF PORTACATH for administration of cytotoxic therapy including placement of reservoir (Anaes.) (Assist.) Fee: \$512.80	Benefit: 75% = \$384.60	85% = \$455.70
30402	RETROPERITONEAL ABSCESS, drainage of, not involving laparotomy (Anaes.) (Assist.) Fee: \$376.70	Benefit: 75% = \$282.55	85% = \$320.20
30403	VENTRAL, INCISIONAL, OR RECURRENT HERNIA OR BURST ABDOMEN, repair of (Anaes.) (Assist.) Fee: \$422.60	Benefit: 75% = \$316.95	85% = \$365.50
30405	VENTRAL OR INCISIONAL HERNIA, repair of, requiring muscle transposition, mesh hernioplasty or resection of strangulated bowel (Anaes.) (Assist.) Fee: \$741.80	Benefit: 75% = \$556.35	85% = \$684.70
30406	PARACENTESIS ABDOMINIS (Anaes.) Fee: \$42.35	Benefit: 75% = \$31.80	85% = \$36.00
30408	PERITONEO venous (Leveen) shunt, insertion of (Anaes.) (Assist.) Fee: \$317.90	Benefit: 75% = \$238.45	85% = \$270.25
30409	LIVER BIOPSY, percutaneous (Anaes.) Fee: \$141.50	Benefit: 75% = \$106.15	85% = \$120.30
30411	LIVER BIOPSY by wedge excision when performed in conjunction with another intraabdominal procedure (Anaes.) Fee: \$72.00	Benefit: 75% = \$54.00	85% = \$61.20

OPERATIONS		GENERAL
30412	LIVER BIOPSY by core needle, when performed in conjunction with another intra-abdominal procedure (Anaes.) Fee: \$42.45 Benefit: 75% = \$31.85 85% = \$36.10	
30414	LIVER, subsegmental resection of, (local excision), other than for trauma (Anaes.) (Assist.) Fee: \$559.25 Benefit: 75% = \$419.45 85% = \$502.15	
30415	LIVER, segmental resection of, other than for trauma (Anaes.) (Assist.) Fee: \$1,118.55 Benefit: 75% = \$838.95 85% = \$1,061.45	
30416	LIVER CYST, laparoscopic marsupialisation of, where the size of the cyst is greater than 5cm in diameter (Anaes.) (Assist.) Fee: \$607.30 Benefit: 75% = \$455.50 85% = \$550.20	
30417	LIVER CYSTS, laparoscopic marsupialisation of 5 or more, including any cyst greater than 5cm in diameter (Anaes.) (Assist.) Fee: \$910.90 Benefit: 75% = \$683.20 85% = \$853.80	
30418	LIVER, lobectomy of, other than for trauma (Anaes.) (Assist.) Fee: \$1,295.15 Benefit: 75% = \$971.40 85% = \$1,238.05	
30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy (Anaes.) (Assist.) Fee: \$662.55 Benefit: 75% = \$496.95 85% = \$605.45	
30421	LIVER, TRI-SEGMENTAL RESECTION (extended lobectomy) of, other than for trauma (Anaes.) (Assist.) Fee: \$1,618.80 Benefit: 75% = \$1,214.10 85% = \$1,561.70	
30422	LIVER, repair of superficial laceration of, for trauma (Anaes.) (Assist.) Fee: \$547.50 Benefit: 75% = \$410.65 85% = \$490.40	
30425	LIVER, repair of deep multiple lacerations of, or debridement of, for trauma (Anaes.) (Assist.) Fee: \$1,059.60 Benefit: 75% = \$794.70 85% = \$1,002.50	
30427	LIVER, segmental resection of, for trauma (Anaes.) (Assist.) Fee: \$1,265.60 Benefit: 75% = \$949.20 85% = \$1,208.50	
30428	LIVER, lobectomy of, for trauma (Anaes.) (Assist.) Fee: \$1,353.95 Benefit: 75% = \$1,015.50 85% = \$1,296.85	
30430	LIVER, extended lobectomy (tri-segmental resection) of, for trauma (Anaes.) (Assist.) Fee: \$1,883.70 Benefit: 75% = \$1,412.80 85% = \$1,826.60	
30431	LIVER ABSCESS, open abdominal drainage of (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50	
30433	LIVER ABSCESS (multiple), open abdominal drainage of (Anaes.) (Assist.) Fee: \$588.70 Benefit: 75% = \$441.55 85% = \$531.60	
30434	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles (Anaes.) (Assist.) Fee: \$476.90 Benefit: 75% = \$357.70 85% = \$419.80	
30436	HYDATID CYST OF LIVER, peritoneum or viscus, complete removal of contents of, with or without suture of biliary radicles, with omentoplasty or myeloplasty (Anaes.) (Assist.) Fee: \$529.80 Benefit: 75% = \$397.35 85% = \$472.70	
30437	HYDATID CYST OF LIVER, total excision of, by cysto-pericystectomy (membrane plus fibrous wall) (Anaes.) (Assist.) Fee: \$659.35 Benefit: 75% = \$494.55 85% = \$602.25	
30438	HYDATID CYST OF LIVER, excision of, with drainage and excision of liver tissue (Anaes.) (Assist.) Fee: \$933.05 Benefit: 75% = \$699.80 85% = \$875.95	
30439	OPERATIVE CHOLANGIOGRAPHY OR OPERATIVE PANCREATOGRAPHY OR INTRA OPERATIVE ULTRASOUND of the biliary tract (including 1 or more examinations performed during the 1 operation) (Anaes.) (Assist.) Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00	
30440	CHOLANGIOGRAM, percutaneous transhepatic, and biliary drainage, using interventional imaging techniques - but not including imaging (Anaes.) (Assist.) Fee: \$426.75 Benefit: 75% = \$320.10 85% = \$369.65	

OPERATIONS		GENERAL
30441	INTRA OPERATIVE ULTRASOUND for staging of intra abdominal tumours (Anaes.) Fee: \$110.45 Benefit: 75% = \$82.85 85% = \$93.90	
30442	CHOLEDOCHOSCOPY in conjunction with another procedure (Anaes.) Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00	
30443	CHOLECYSTECTOMY (Anaes.) (Assist.) Fee: \$599.40 Benefit: 75% = \$449.55 85% = \$542.30	
30445	LAPAROSCOPIC CHOLECYSTECTOMY (Anaes.) (Assist.) Fee: \$599.40 Benefit: 75% = \$449.55 85% = \$542.30	
30446	LAPAROSCOPIC CHOLECYSTECTOMY when procedure is completed by laparotomy (Anaes.) (Assist.) Fee: \$599.40 Benefit: 75% = \$449.55 85% = \$542.30	
30448	LAPAROSCOPIC CHOLECYSTECTOMY, involving removal of common duct calculi via the cystic duct (Anaes.) (Assist.) Fee: \$788.85 Benefit: 75% = \$591.65 85% = \$731.75	
30449	LAPAROSCOPIC CHOLECYSTECTOMY with removal of common duct calculi via laparoscopic choledochotomy (Anaes.) (Assist.) Fee: \$877.15 Benefit: 75% = \$657.90 85% = \$820.05	
30450	CALCULUS OF BILIARY OR RENAL TRACT, extraction of, using interventional imaging techniques - not being a service associated with a service to which items 36627 , 36630 , 36645 or 36648 applies (Anaes.) (Assist.) Fee: \$425.10 Benefit: 75% = \$318.85 85% = \$368.00	
30451	BILIARY DRAINAGE TUBE, exchange of, using interventional imaging techniques - but not including imaging (Anaes.) (Assist.) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
30452	CHOLEDOCHOSCOPY with balloon dilation of a stricture or passage of stent or extraction of calculi (Anaes.) (Assist.) Fee: \$306.10 Benefit: 75% = \$229.60 85% = \$260.20	
30454	CHOLEDOCHOTOMY (with or without cholecystectomy), with or without removal of calculi (Anaes.) (Assist.) Fee: \$699.25 Benefit: 75% = \$524.45 85% = \$642.15	
30455	CHOLEDOCHOTOMY (with or without cholecystectomy), with removal of calculi including biliary intestinal anastomosis (Anaes.) (Assist.) Fee: \$822.20 Benefit: 75% = \$616.65 85% = \$765.10	
30457	CHOLEDOCHOTOMY, intrahepatic, involving removal of intrahepatic bile duct calculi (Anaes.) (Assist.) Fee: \$1,118.55 Benefit: 75% = \$838.95 85% = \$1,061.45	
30458	TRANSDUODENAL OPERATION ON SPHINCTER OF ODDI, involving 1 or more of, removal of calculi, sphincterotomy, sphincteroplasty, biopsy, local excision of peri-ampullary or duodenal tumour, sphincteroplasty of the pancreatic duct, pancreatic duct septoplasty, with or without choledochotomy (Anaes.) (Assist.) Fee: \$822.20 Benefit: 75% = \$616.65 85% = \$765.10	
30460	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY or Roux-en-Y as a bypass procedure when no prior biliary surgery performed (Anaes.) (Assist.) Fee: \$699.25 Benefit: 75% = \$524.45 85% = \$642.15	
30461	RADICAL RESECTION of porta hepatis with biliary-enteric anastomoses, not being a service associated with a service to which item 30443 , 30454 , 30455 , 30458 or 30460 applies (Anaes.) (Assist.) Fee: \$1,198.70 Benefit: 75% = \$899.05 85% = \$1,141.60	
30463	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, with 2 duct anastomoses (Anaes.) (Assist.) Fee: \$1,471.65 Benefit: 75% = \$1,103.75 85% = \$1,414.55	
30464	RADICAL RESECTION of common hepatic duct and right and left hepatic ducts, involving more than 2 anastomoses or resection of segment or major portion of segment of liver (Anaes.) (Assist.) Fee: \$1,766.10 Benefit: 75% = \$1,324.60 85% = \$1,709.00	
30466	INTRAHEPATIC biliary bypass of left hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) Fee: \$1,018.45 Benefit: 75% = \$763.85 85% = \$961.35	

OPERATIONS		GENERAL
30467	INTRAHEPATIC BYPASS of right hepatic ductal system by Roux-en-Y loop to peripheral ductal system (Anaes.) (Assist.) Fee: \$1,259.75 Benefit: 75% = \$944.85 85% = \$1,202.65	
30469	BILIARY STRICTURE, repair of, after 1 or more operations on the biliary tree (Anaes.) (Assist.) Fee: \$1,395.20 Benefit: 75% = \$1,046.40 85% = \$1,338.10	
30472	HEPATIC OR COMMON BILE DUCT, repair of, as the primary procedure subsequent to partial or total transection of bile duct or ducts (Anaes.) (Assist.) Fee: \$753.50 Benefit: 75% = \$565.15 85% = \$696.40	
30473	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with or without biopsy, not being a service associated with a service to which item 30476 or 30478 applies (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$143.60 Benefit: 75% = \$107.70 85% = \$122.10	
30475	ENDOSCOPY with balloon dilatation of gastric or gastroduodenal stricture (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$259.65 Benefit: 75% = \$194.75 85% = \$220.75	
30476	OESOPHAGOSCOPY (not being a service to which item 41816 or 41822 applies), GASTROSCOPY, DUODENOSCOPY or PANENDOSCOPY (1 or more such procedures), with endoscopic sclerosing injection or banding of oesophageal or gastric varices, not being a service associated with a service to which item 30473 or 30478 applies (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$199.10 Benefit: 75% = \$149.35 85% = \$169.25	
30478	OESOPHAGOSCOPY (not being a service to which item 41816 , 41822 or 41825 applies), gastroscopy, duodenoscopy or panendoscopy (1 or more such procedures), with 1 or more of the following endoscopic procedures - polypectomy, removal of foreign body, diathermy, heater probe or laser coagulation, or sclerosing injection of bleeding upper gastrointestinal lesions, not being a service associated with a service to which item 30473 or 30476 applies (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$199.10 Benefit: 75% = \$149.35 85% = \$169.25	
30479	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions or strictures of the gastrointestinal tract (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$386.00 Benefit: 75% = \$289.50 85% = \$328.90	
30481	PERCUTANEOUS GASTROSTOMY (initial procedure), including any associated imaging services (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$289.45 Benefit: 75% = \$217.10 85% = \$246.05	
30482	PERCUTANEOUS GASTROSTOMY (repeat procedure), including any associated imaging services (Anaes.) Fee: \$205.80 Benefit: 75% = \$154.35 85% = \$174.95	
30483	GASTROSTOMY BUTTON, non-endoscopic insertion of, or non-endoscopic replacement of (Anaes.) Fee: \$143.55 Benefit: 75% = \$107.70 85% = \$122.05	
30484	ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$295.85 Benefit: 75% = \$221.90 85% = \$251.50	
30485	ENDOSCOPIC SPHINCTEROTOMY with or without extraction of stones from common bile duct (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$456.70 Benefit: 75% = \$342.55 85% = \$399.60	
30487	SMALL BOWEL INTUBATION with biopsy (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$146.70 Benefit: 75% = \$110.05 85% = \$124.70	
30488	SMALL BOWEL INTUBATION as an independent procedure (Anaes.) Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05	
30490	OESOPHAGEAL PROSTHESIS, insertion of, including endoscopy and dilatation (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$426.75 Benefit: 75% = \$320.10 85% = \$369.65	

OPERATIONS		GENERAL	
30491	BILE DUCT, ENDOSCOPIC STENTING OF (including endoscopy and dilatation) (Anaes.) (See para T8.17 of explanatory notes to this Category) Fee: \$450.25 Benefit: 75% = \$337.70 85% = \$393.15		
30493	BILIARY MANOMETRY (Anaes.) (See para T8.17 of explanatory notes to this Category) Fee: \$270.20 Benefit: 75% = \$202.65 85% = \$229.70		
30494	ENDOSCOPIC BILIARY DILATATION (Anaes.) (See para T8.17 of explanatory notes to this Category) Fee: \$340.90 Benefit: 75% = \$255.70 85% = \$289.80		
30496	VAGOTOMY, truncal or selective, with or without pyloroplasty or gastroenterostomy (Anaes.) (Assist.) Fee: \$476.90 Benefit: 75% = \$357.70 85% = \$419.80		
30497	VAGOTOMY and ANTRECTOMY (Anaes.) (Assist.) Fee: \$568.55 Benefit: 75% = \$426.45 85% = \$511.45		
30499	VAGOTOMY, highly selective (Anaes.) (Assist.) Fee: \$676.30 Benefit: 75% = \$507.25 85% = \$619.20		
30500	VAGOTOMY, highly selective with duodenoplasty for peptic stricture (Anaes.) (Assist.) Fee: \$724.05 Benefit: 75% = \$543.05 85% = \$666.95		
30502	VAGOTOMY, highly selective, with dilatation of pylorus (Anaes.) (Assist.) Fee: \$799.20 Benefit: 75% = \$599.40 85% = \$742.10		
30503	VAGOTOMY or ANTRECTOMY, or both, for peptic ulcer following previous operation for peptic ulcer (Anaes.) (Assist.) Fee: \$894.90 Benefit: 75% = \$671.20 85% = \$837.80		
30505	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision (Anaes.) (Assist.) Fee: \$447.35 Benefit: 75% = \$335.55 85% = \$390.25		
30506	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and vagotomy and pyloroplasty or gastroenterostomy (Anaes.) (Assist.) Fee: \$783.00 Benefit: 75% = \$587.25 85% = \$725.90		
30508	BLEEDING PEPTIC ULCER, control of, involving suture of bleeding point or wedge excision, and highly selective vagotomy (Anaes.) (Assist.) Fee: \$824.20 Benefit: 75% = \$618.15 85% = \$767.10		
30509	BLEEDING PEPTIC ULCER, control of, involving gastric resection (other than wedge resection) (Anaes.) (Assist.) Fee: \$824.20 Benefit: 75% = \$618.15 85% = \$767.10		
30511	(see Item 31441 for repair, revision or replacement of implanted reservoir associated with adjustable gastric band) MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.) Fee: \$688.80 Benefit: 75% = \$516.60 85% = \$631.70		
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.) Fee: \$847.60 Benefit: 75% = \$635.70 85% = \$790.50		
30514	MORBID OBESITY, surgical reversal of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) Fee: \$1,247.95 Benefit: 75% = \$936.00 85% = \$1,190.85		
30515	GASTROENTEROSTOMY (INCLUDING GASTRODUODENOSTOMY) OR ENTEROCOLOSTOMY OR ENTEROENTEROSTOMY (Anaes.) (Assist.) Fee: \$571.00 Benefit: 75% = \$428.25 85% = \$513.90		
30517	GASTROENTEROSTOMY, PYLOROPLASTY or GASTRODUODENOSTOMY, reconstruction of (Anaes.) (Assist.) Fee: \$747.65 Benefit: 75% = \$560.75 85% = \$690.55		
30518	PARTIAL GASTRECTOMY (Anaes.) (Assist.) Fee: \$800.65 Benefit: 75% = \$600.50 85% = \$743.55		
30520	GASTRIC TUMOUR, removal of, by local excision, not being a service to which item 30518 applies (Anaes.) (Assist.) Fee: \$547.50 Benefit: 75% = \$410.65 85% = \$490.40		

OPERATIONS		GENERAL
30521	GASTRECTOMY, TOTAL, for benign disease (Anaes.) (Assist.) Fee: \$1,171.50 Benefit: 75% = \$878.65 85% = \$1,114.40	
30523	GASTRECTOMY, SUBTOTAL RADICAL, for carcinoma, (including splenectomy when performed) (Anaes.) (Assist.) <i>(See para T8.18 of explanatory notes to this Category)</i> Fee: \$1,224.35 Benefit: 75% = \$918.30 85% = \$1,167.25	
30524	GASTRECTOMY, TOTAL RADICAL, for carcinoma (including extended node dissection and distal pancreatectomy and splenectomy when performed) (Anaes.) (Assist.) Fee: \$1,348.05 Benefit: 75% = \$1,011.05 85% = \$1,290.95	
30526	GASTRECTOMY, TOTAL, and including lower oesophagus, performed by left thoraco-abdominal incision or opening of diaphragmatic hiatus, (including splenectomy when performed) (Anaes.) (Assist.) Fee: \$1,748.30 Benefit: 75% = \$1,311.25 85% = \$1,691.20	
30527	ANTIREFLUX OPERATION by fundoplasty, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus not being a service to which item 30601 applies (Anaes.) (Assist.) <i>(See para T8.19 of explanatory notes to this Category)</i> Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35	
30529	ANTIREFLUX operation by fundoplasty, with OESOPHAGOPLASTY for stricture or short oesophagus (Anaes.) (Assist.) <i>(See para T8.19 of explanatory notes to this Category)</i> Fee: \$1,059.60 Benefit: 75% = \$794.70 85% = \$1,002.50	
30530	ANTIREFLUX operation by cardiopexy, with or without fundoplasty (Anaes.) (Assist.) <i>(See para T8.19 of explanatory notes to this Category)</i> Fee: \$635.80 Benefit: 75% = \$476.85 85% = \$578.70	
30532	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) <i>(See para T8.19 of explanatory notes to this Category)</i> Fee: \$730.05 Benefit: 75% = \$547.55 85% = \$672.95	
30533	OESOPHAGOGASTRIC MYOTOMY (Heller's operation) via abdominal or thoracic approach, WITH FUNDOPLASTY, with or without closure of the diaphragmatic hiatus, by laparoscopy or open operation (Anaes.) (Assist.) <i>(See para T8.19 of explanatory notes to this Category)</i> Fee: \$868.40 Benefit: 75% = \$651.30 85% = \$811.30	
30535	OESOPHAGECTOMY with gastric reconstruction by abdominal mobilisation and thoracotomy (Anaes.) (Assist.) Fee: \$1,375.55 Benefit: 75% = \$1,031.70 85% = \$1,318.45	
30536	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - 1 surgeon (Anaes.) (Assist.) Fee: \$1,395.20 Benefit: 75% = \$1,046.40 85% = \$1,338.10	
30538	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest- conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$965.45 Benefit: 75% = \$724.10 85% = \$908.35	
30539	OESOPHAGECTOMY involving gastric reconstruction by abdominal mobilisation, thoracotomy and anastomosis in the neck or chest - conjoint surgery, co-surgeon (Assist.) Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35	
30541	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - 1 surgeon (Anaes.) (Assist.) Fee: \$1,230.35 Benefit: 75% = \$922.80 85% = \$1,173.25	
30542	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$835.90 Benefit: 75% = \$626.95 85% = \$778.80	
30544	OESOPHAGECTOMY, by trans-hiatal oesophagectomy (cervical and abdominal mobilisation, anastomosis) with posterior or anterior mediastinal placement - conjoint surgery, co-surgeon (Assist.) Fee: \$612.25 Benefit: 75% = \$459.20 85% = \$555.15	

OPERATIONS		GENERAL
30545	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - 1 surgeon (Anaes.) (Assist.) Fee: \$1,489.45 Benefit: 75% = \$1,117.10 85% = \$1,432.35	
30547	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,024.30 Benefit: 75% = \$768.25 85% = \$967.20	
30548	OESOPHAGECTOMY with colon or jejunal anastomosis, (abdominal and thoracic mobilisation with thoracic anastomosis) - conjoint surgery, co-surgeon (Assist.) Fee: \$765.25 Benefit: 75% = \$573.95 85% = \$708.15	
30550	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - 1 surgeon (Anaes.) (Assist.) Fee: \$1,671.90 Benefit: 75% = \$1,253.95 85% = \$1,614.80	
30551	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,153.85 Benefit: 75% = \$865.40 85% = \$1,096.75	
30553	OESOPHAGECTOMY with colon or jejunal replacement (abdominal and thoracic mobilisation with anastomosis of pedicle in the neck) - conjoint surgery, co-surgeon (Assist.) Fee: \$853.50 Benefit: 75% = \$640.15 85% = \$796.40	
30554	OESOPHAGECTOMY with reconstruction by free jejunal graft - 1 surgeon (Anaes.) (Assist.) Fee: \$1,860.25 Benefit: 75% = \$1,395.20 85% = \$1,803.15	
30556	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, principal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,283.30 Benefit: 75% = \$962.50 85% = \$1,226.20	
30557	OESOPHAGECTOMY with reconstruction by free jejunal graft - conjoint surgery, co-surgeon (Assist.) Fee: \$947.75 Benefit: 75% = \$710.85 85% = \$890.65	
30559	OESOPHAGUS, local excision for tumour of (Anaes.) (Assist.) Fee: \$688.80 Benefit: 75% = \$516.60 85% = \$631.70	
30560	OESOPHAGEAL PERFORATION, repair of, by thoracotomy (Anaes.) (Assist.) Fee: \$765.25 Benefit: 75% = \$573.95 85% = \$708.15	
30562	ENTEROSTOMY or COLOSTOMY, closure of not involving resection of bowel (Anaes.) (Assist.) Fee: \$482.45 Benefit: 75% = \$361.85 85% = \$425.35	
30563	COLOSTOMY OR ILEOSTOMY, refashioning of (Anaes.) (Assist.) Fee: \$482.45 Benefit: 75% = \$361.85 85% = \$425.35	
30564	SMALL BOWEL STRICTUREPLASTY for chronic inflammatory bowel disease (Anaes.) (Assist.) Fee: \$626.15 Benefit: 75% = \$469.65 85% = \$569.05	
30565	SMALL INTESTINE, resection of, without anastomosis (including formation of stoma) (Anaes.) (Assist.) Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35	
30566	SMALL INTESTINE, resection of, with anastomosis (Anaes.) (Assist.) Fee: \$784.75 Benefit: 75% = \$588.60 85% = \$727.65	
30568	INTRAOPERATIVE ENTEROTOMY for visualisation of the small intestine by endoscopy (Anaes.) (Assist.) Fee: \$588.70 Benefit: 75% = \$441.55 85% = \$531.60	
30569	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed at laparotomy, with or without biopsies (Anaes.) (Assist.) Fee: \$300.15 Benefit: 75% = \$225.15 85% = \$255.15	
30571	APPENDICECTOMY, not being a service to which item 30574 applies (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00	
30572	LAPAROSCOPIC APPENDICECTOMY (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00	

OPERATIONS	GENERAL
30574	<p>NOTE: <i>Multiple Operation and Multiple Anaesthetic rules apply to this item</i></p> <p>APPENDICECTOMY, when performed in conjunction with any other intraabdominal procedure through the same incision (Anaes.)</p> <p>Fee: \$99.95 Benefit: 75% = \$75.00 85% = \$85.00</p>
30575	<p>PANCREATIC ABSCESS, laparotomy and external drainage of, not requiring retro-pancreatic dissection (Anaes.) (Assist.)</p> <p>Fee: \$415.75 Benefit: 75% = \$311.85 85% = \$358.65</p>
30577	<p>PANCREATIC NECROSECTOMY for PANCREATIC NECROSIS or ABSCESS FORMATION requiring major pancreatic or retro-pancreatic dissection, excluding aftercare (Anaes.) (Assist.)</p> <p>Fee: \$883.05 Benefit: 75% = \$662.30 85% = \$825.95</p>
30578	<p>ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of pancreatic tumour (Anaes.) (Assist.)</p> <p>Fee: \$930.15 Benefit: 75% = \$697.65 85% = \$873.05</p>
30580	<p>ENDOCRINE TUMOUR, exploration of pancreas or duodenum, followed by local excision of duodenal tumour (Anaes.) (Assist.)</p> <p>Fee: \$847.60 Benefit: 75% = \$635.70 85% = \$790.50</p>
30581	<p>ENDOCRINE TUMOUR, exploration of pancreas or duodenum for, but no tumour found (Anaes.) (Assist.)</p> <p>Fee: \$618.15 Benefit: 75% = \$463.65 85% = \$561.05</p>
30583	<p>DISTAL PANCREATECTOMY (Anaes.) (Assist.)</p> <p>Fee: \$968.30 Benefit: 75% = \$726.25 85% = \$911.20</p>
30584	<p>PANCREATICO-DUODENECTOMY, WHIPPLE'S OPERATION, with or without preservation of pylorus (Anaes.) (Assist.)</p> <p>Fee: \$1,429.25 Benefit: 75% = \$1,071.95 85% = \$1,372.15</p>
30586	<p>PANCREATIC CYST ANASTOMOSIS TO STOMACH OR DUODENUM - by open or endoscopic means (Anaes.) (Assist.)</p> <p>Fee: \$568.55 Benefit: 75% = \$426.45 85% = \$511.45</p>
30587	<p>PANCREATIC CYST, anastomosis to Roux loop of jejunum (Anaes.) (Assist.)</p> <p>Fee: \$588.70 Benefit: 75% = \$441.55 85% = \$531.60</p>
30589	<p>PANCREATICO-JEJUNOSTOMY for pancreatitis or trauma (Anaes.) (Assist.)</p> <p>Fee: \$1,014.30 Benefit: 75% = \$760.75 85% = \$957.20</p>
30590	<p>PANCREATICO-JEJUNOSTOMY following previous pancreatic surgery (Anaes.) (Assist.)</p> <p>Fee: \$1,118.55 Benefit: 75% = \$838.95 85% = \$1,061.45</p>
30593	<p>PANCREATECTOMY, near total or total (including duodenum), with or without splenectomy (Anaes.) (Assist.)</p> <p>Fee: \$1,530.60 Benefit: 75% = \$1,147.95 85% = \$1,473.50</p>
30594	<p>PANCREATECTOMY for pancreatitis following previously attempted drainage procedure or partial resection (Anaes.) (Assist.)</p> <p>Fee: \$1,766.10 Benefit: 75% = \$1,324.60 85% = \$1,709.00</p>
30596	<p>SPLENORRHAPHY OR PARTIAL SPLENECTOMY (Anaes.) (Assist.)</p> <p>Fee: \$727.50 Benefit: 75% = \$545.65 85% = \$670.40</p>
30597	<p>SPLENECTOMY (Anaes.) (Assist.)</p> <p>Fee: \$583.95 Benefit: 75% = \$438.00 85% = \$526.85</p>
30599	<p>SPLENECTOMY, for massive spleen (weighing more than 1500 grams) or involving thoraco-abdominal incision (Anaes.) (Assist.)</p> <p>Fee: \$1,059.60 Benefit: 75% = \$794.70 85% = \$1,002.50</p>
30600	<p>DIAPHRAGMATIC HERNIA, TRAUMATIC, repair of (Anaes.) (Assist.)</p> <p>Fee: \$630.10 Benefit: 75% = \$472.60 85% = \$573.00</p>
30601	<p>DIAPHRAGMATIC HERNIA, CONGENITAL repair of, by thoracic or abdominal approach (Anaes.) (Assist.)</p> <p>Fee: \$776.15 Benefit: 75% = \$582.15 85% = \$719.05</p>
30602	<p>PORTAL HYPERTENSION, porto-caval shunt for (Anaes.) (Assist.)</p> <p>Fee: \$1,259.75 Benefit: 75% = \$944.85 85% = \$1,202.65</p>
30603	<p>PORTAL HYPERTENSION, meso-caval shunt for (Anaes.) (Assist.)</p> <p>Fee: \$1,330.45 Benefit: 75% = \$997.85 85% = \$1,273.35</p>

OPERATIONS		GENERAL	
30605	PORTAL HYPERTENSION, selective spleno-renal shunt for (Anaes.) (Assist.) Fee: \$1,512.95	Benefit: 75% = \$1,134.75	85% = \$1,455.85
30606	PORTAL HYPERTENSION, oesophageal transection via stapler or oversew of gastric varices with or without devascularisation (Anaes.) (Assist.) Fee: \$900.65	Benefit: 75% = \$675.50	85% = \$843.55
30609	FEMORAL OR INGUINAL HERNIA, laparoscopic repair of, not being a service associated with a service to which item 30612 or 30614 applies (Anaes.) (Assist.) Fee: \$376.60	Benefit: 75% = \$282.45	85% = \$320.15
30612 G 30614 S	FEMORAL OR INGUINAL HERNIA OR INFANTILE HYDROCELE, repair of, not being a service to which item 30403 or 30615 applies (Anaes.) (Assist.) Fee: \$288.95 Fee: \$376.60	Benefit: 75% = \$216.75 Benefit: 75% = \$282.45	85% = \$245.65 85% = \$320.15
30615	STRANGULATED, INCARCERATED OR OBSTRUCTED HERNIA, repair of, without bowel resection (Anaes.) (Assist.) Fee: \$422.60	Benefit: 75% = \$316.95	85% = \$365.50
30616 G 30617 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person under 10 years of age (Anaes.) Fee: \$215.10 Fee: \$288.95	Benefit: 75% = \$161.35 Benefit: 75% = \$216.75	85% = \$182.85 85% = \$245.65
30620 G 30621 S	UMBILICAL, EPIGASTRIC OR LINEA ALBA HERNIA, repair of, in a person 10 years of age or over (Anaes.) (Assist.) Fee: \$242.80 Fee: \$330.45	Benefit: 75% = \$182.10 Benefit: 75% = \$247.85	85% = \$206.40 85% = \$280.90
30628	HYDROCELE, tapping of Fee: \$28.90	Benefit: 75% = \$21.70	85% = \$24.60
30631	HYDROCELE, removal of, not being a service associated with a service to which items 30638 , 30641 and 30644 apply (Anaes.) Fee: \$191.85	Benefit: 75% = \$143.90	85% = \$163.10
30634 G 30635 S	VARICOCELE, surgical correction of, not being a service associated with a service to which items 30638 , 30641 and 30644 apply, 1 procedure (Anaes.) (Assist.) Fee: \$190.60 Fee: \$236.65	Benefit: 75% = \$142.95 Benefit: 75% = \$177.50	85% = \$162.05 85% = \$201.20
30638 G 30641 S	ORCHIDECTOMY, simple or subscapsular, unilateral with or without insertion of testicular prosthesis (Anaes.) (Assist.) Fee: \$242.80 Fee: \$330.45	Benefit: 75% = \$182.10 Benefit: 75% = \$247.85	85% = \$206.40 85% = \$280.90
30644	EXPLORATION OF SPERMATIC CORD, inguinal approach, with or without testicular biopsy and with or without excision of spermatic cord and testis (Anaes.) (Assist.) Fee: \$422.60	Benefit: 75% = \$316.95	85% = \$365.50
30653	CIRCUMCISION of a male UNDER 6 MONTHS of age (Anaes.) Fee: \$37.70	Benefit: 75% = \$28.30	85% = \$32.05
30656	CIRCUMCISION of a male UNDER 10 YEARS of age but not less than 6 months of age (Anaes.) Fee: \$87.65	Benefit: 75% = \$65.75	85% = \$74.55
30659 G 30660 S	CIRCUMCISION of a male 10 YEARS OF AGE OR OVER (Anaes.) Fee: \$121.40 Fee: \$150.55	Benefit: 75% = \$91.05 Benefit: 75% = \$112.95	85% = \$103.20 85% = \$128.00
30663	HAEMORRHAGE, arrest of, following circumcision requiring general anaesthesia (Anaes.) Fee: \$117.05	Benefit: 75% = \$87.80	85% = \$99.50
30666	PARAPHIMOSIS, reduction of, under general anaesthesia, with or without dorsal incision, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$38.50	Benefit: 75% = \$28.90	85% = \$32.75
30672	COCCYX, excision of (Anaes.) (Assist.) Fee: \$361.15	Benefit: 75% = \$270.90	85% = \$307.00

OPERATIONS		GENERAL
30675 G 30676 S	PILONIDAL SINUS OR CYST, OR SACRAL SINUS OR CYST, excision of (Anaes.) Fee: \$242.80 Benefit: 75% = \$182.10 85% = \$206.40	Benefit: 75% = \$230.55 85% = \$261.25
30679	PILONIDAL SINUS, injection of sclerosant fluid under anaesthesia (Anaes.) Fee: \$78.05 Benefit: 75% = \$58.55 85% = \$66.35	
31000	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 6 or fewer sections (Anaes.) Fee: \$470.95 Benefit: 75% = \$353.25 85% = \$413.85	
31001	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 7 to 12 sections (inclusive) (Anaes.) Fee: \$588.70 Benefit: 75% = \$441.55 85% = \$531.60	
31002	MICROGRAPHICALLY CONTROLLED SERIAL EXCISION of skin tumour utilising horizontal frozen sections with mapping of all excised tissue, and histological examination of all excised tissue by the specialist performing the procedure - 13 or more sections (Anaes.) Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35	
31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane , not being a service to which another item in this Group applies (See para T8.20 of explanatory notes to this Category) Fee: \$27.55 Benefit: 75% = \$20.70 85% = \$23.45	
31205	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size up to 10mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 , <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$77.35 Benefit: 75% = \$58.05 85% = \$65.75	
31210	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size more than 10mm and up to 20mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 , <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) item (See para T8.20 of explanatory notes to this Category) Fee: \$99.80 Benefit: 75% = \$74.85 85% = \$84.85	
31215	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), lesion size more than 20mm in diameter, removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 , <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$116.35 Benefit: 75% = \$87.30 85% = \$98.90	
31220	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), lesion size up to 10mm in diameter, removal of 4 to 10 lesions by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 , <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$173.95 Benefit: 75% = \$130.50 85% = \$147.90	
31225	TUMOURS (other than viral verrucae [common warts] and seborrheic keratoses), CYSTS, ULCERS OR SCARS (other than scars removed during the surgical approach at an operation), lesion size up to 10mm in diameter, removal of more than 10 lesions by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 - <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 of explanatory notes to this Category) Fee: \$309.15 Benefit: 75% = \$231.90 85% = \$262.80	

OPERATIONS	GENERAL
31230	<p>TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal by surgical excision and suture from nose, eyelid, lip, ear, digit or genitalia, including excision to establish the diagnosis of tumours covered by items 31300 to 31335 - <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$136.25 Benefit: 75% = \$102.20 85% = \$115.85</p>
31235	<p>TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), including excision to establish the diagnosis of tumours covered by items 31300 to 31335, lesion size up to 10mm in diameter - <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 and T8.21 of explanatory notes to this Category)</p> <p>Fee: \$116.35 Benefit: 75% = \$87.30 85% = \$98.90</p>
31240	<p>TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle), including excision to establish the diagnosis of tumours covered by items 31300 to 31335, lesion size more than 10mm in diameter - <i>where specimen sent for histological examination</i> (not being a service to which item 30195 applies) (Anaes.) (See para T8.20 and T8.21 of explanatory notes to this Category)</p> <p>Fee: \$136.25 Benefit: 75% = \$102.20 85% = \$115.85</p>
31245	<p>SKIN AND SUBCUTANEOUS TISSUE, extensive excision of, in the treatment of SUPPURATIVE HYDRADENITIS (excision from axilla, groin or natal cleft) or SYCOSIS BARBAE or NUCHAE (excision from face or neck) (Anaes.) (See para T8.20 and T8.21 of explanatory notes to this Category)</p> <p>Fee: \$299.15 Benefit: 75% = \$224.40 85% = \$254.30</p>
31250	<p>GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface <i>where the specimen is sent for histological confirmation of diagnosis</i> (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$299.15 Benefit: 75% = \$224.40 85% = \$254.30</p>
31255	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$179.50 Benefit: 75% = \$134.65 85% = \$152.60</p>
31260	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$255.95 Benefit: 75% = \$192.00 85% = \$217.60</p>
31265	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to 10mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 and T8.21 of explanatory notes to this Category)</p> <p>Fee: \$149.55 Benefit: 75% = \$112.20 85% = \$127.15</p>
31270	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to 20mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 and T8.21 of explanatory notes to this Category)</p> <p>Fee: \$209.40 Benefit: 75% = \$157.05 85% = \$178.00</p>
31275	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 and T8.21 of explanatory notes to this Category)</p> <p>Fee: \$242.65 Benefit: 75% = \$182.00 85% = \$206.30</p>

OPERATIONS	GENERAL
31280	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from areas of the body not covered by items 31255 and 31265, tumour size up to 10mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$126.35 Benefit: 75% = \$94.80 85% = \$107.40</p>
31285	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from areas of the body not covered by items 31260 and 31270, tumour size more than 10mm and up to 20mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$172.75 Benefit: 75% = \$129.60 85% = \$146.85</p>
31290	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), removal from areas of the body not covered by items 31260 and 31275, tumour size more than 20mm in diameter - where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$199.35 Benefit: 75% = \$149.55 85% = \$169.45</p>
31295	<p>BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA, residual or recurrent (where lesion treated by previous surgery, serial cautery and curettage, radiotherapy or two prolonged freeze/thaw cycles of liquid nitrogen therapy), performed by a specialist in the practice of his or her specialty or by a practitioner other than the practitioner who provided the previous treatment, removal from the head or neck (anterior to the sternomastoid muscles), where removal is by surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$237.45 Benefit: 75% = \$178.10 85% = \$201.85</p>
31300	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$259.35 Benefit: 75% = \$194.55 85% = \$220.45</p>
31305	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$319.05 Benefit: 75% = \$239.30 85% = \$271.20</p>
31310	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size up to 10mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 and T8.21 of explanatory notes to this Category)</i></p> <p>Fee: \$225.95 Benefit: 75% = \$169.50 85% = \$192.10</p>
31315	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 10mm and up to 20mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 and T8.21 of explanatory notes to this Category)</i></p> <p>Fee: \$285.80 Benefit: 75% = \$214.35 85% = \$242.95</p>
31320	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle) tumour size more than 20mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 and T8.21 of explanatory notes to this Category)</i></p> <p>Fee: \$319.05 Benefit: 75% = \$239.30 85% = \$271.20</p>
31325	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31300 and 31310 - tumour size up to 10mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) <i>(See para T8.20 of explanatory notes to this Category)</i></p> <p>Fee: \$219.40 Benefit: 75% = \$164.55 85% = \$186.50</p>

OPERATIONS	GENERAL
31330	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31305 and 31310 - tumour size more than 10mm and up to 20mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$259.35 Benefit: 75% = \$194.55 85% = \$220.45</p>
31335	<p>MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - removal from areas of the body not covered by items 31305 and 31320 - tumour size more than 20mm in diameter - where removal is by definitive surgical excision and suture and histological confirmation of malignancy has been obtained (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$299.15 Benefit: 75% = \$224.40 85% = \$254.30</p>
31340	<p>NOTE: Multiple Operation and Multiple Anaesthetic rules apply to this item. MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, performed in association with excision of malignant tumour of skin covered by item 31255, 31260, 31265, 31270, 31275, 31280, 31285, 31290, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335 (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Derived Fee: 75% of the fee for excision of malignant tumour</p>
31345	<p>LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and greater than 50mm in diameter, or is sub-fascial, <i>where specimen is sent for histological confirmation of diagnosis</i> (Anaes.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$170.95 Benefit: 75% = \$128.25 85% = \$145.35</p>
31350	<p>BENIGN TUMOUR of SOFT TISSUE, removal of by surgical excision, where <i>specimen is sent for histological confirmation of diagnosis</i>, not being a service to which another item in this Group applies (Anaes.) (Assist.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$351.35 Benefit: 75% = \$263.55 85% = \$298.65</p>
31355	<p>MALIGNANT TUMOUR of SOFT TISSUE, removal of by surgical excision, where <i>histological proof of malignancy has been obtained</i>, not being a service to which another item in this Group applies (Anaes.) (Assist.) (See para T8.20 of explanatory notes to this Category)</p> <p>Fee: \$579.25 Benefit: 75% = \$434.45 85% = \$522.15</p>
31400	<p>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.) (Assist.)</p> <p>Fee: \$211.65 Benefit: 75% = \$158.75 85% = \$179.95</p>
31403	<p>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.) (Assist.)</p> <p>Fee: \$244.30 Benefit: 75% = \$183.25 85% = \$207.70</p>
31406	<p>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.) (Assist.)</p> <p>Fee: \$407.15 Benefit: 75% = \$305.40 85% = \$350.05</p>
31409	<p>PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.)</p> <p>Fee: \$1,264.90 Benefit: 75% = \$948.70 85% = \$1,207.80</p>
31412	<p>RECURRENT OR PERSISTENT PARAPHARYNGEAL TUMOUR, excision of, by cervical approach (Anaes.) (Assist.) Fee: \$1,558.05 Benefit: 75% = \$1,168.55 85% = \$1,500.95</p>
31420	<p>LYMPH NODE OF NECK, biopsy of (Anaes.)</p> <p>Fee: \$149.10 Benefit: 75% = \$111.85 85% = \$126.75</p>
31423	<p>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.) (Assist.) (See para T8.22 of explanatory notes to this Category)</p> <p>Fee: \$325.70 Benefit: 75% = \$244.30 85% = \$276.85</p>
31426	<p>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.) (Assist.) (See para T8.22 of explanatory notes to this Category)</p> <p>Fee: \$651.45 Benefit: 75% = \$488.60 85% = \$594.35</p>

OPERATIONS		GENERAL	
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.) (Assist.) (See para T8.22 of explanatory notes to this Category) Fee: \$1,015.15 Benefit: 75% = \$761.40 85% = \$958.05		
31432	LYMPH NODES OF NECK, bilateral selective dissection of levels I, II and III (bilateral supraomohyoid dissections) (Anaes.) (Assist.) (See para T8.22 of explanatory notes to this Category) Fee: \$1,085.75 Benefit: 75% = \$814.35 85% = \$1,028.65		
31435	LYMPH NODES OF NECK, comprehensive dissection of all 5 lymph node levels on one side of the neck (Anaes.) (Assist.) (See para T8.22 of explanatory notes to this Category) Fee: \$798.00 Benefit: 75% = \$598.50 85% = \$740.90		
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.) (Assist.) (See para T8.22 of explanatory notes to this Category) Fee: \$1,264.90 Benefit: 75% = \$948.70 85% = \$1,207.80		
31441	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes.) Fee: \$204.05 Benefit: 75% = \$153.05 85% = \$173.45		
31450	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken is 1 hour or less (Anaes.) (Assist.) Fee: \$329.70 Benefit: 75% = \$247.30 85% = \$280.25		
31452	LAPAROSCOPIC DIVISION OF ADHESIONS, as an independent procedure, where the time taken in more than 1 hour (Anaes.) (Assist.) Fee: \$576.90 Benefit: 75% = \$432.70 85% = \$519.80		
31454	LAPAROSCOPY with drainage of pus, bile or blood, as an independent procedure (Anaes.) (Assist.) Fee: \$456.70 Benefit: 75% = \$342.55 85% = \$399.60		
31456	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition (Anaes.) Fee: \$199.10 Benefit: 75% = \$149.35 85% = \$169.25		
31458	GASTROSCOPY and insertion of nasogastric or nasoenteral feeding tube, where blind insertion of the feeding tube has failed or is inappropriate due to the patient's medical condition, and where the use of imaging intensification is clinically indicated (Anaes.) Fee: \$238.95 Benefit: 75% = \$179.25 85% = \$203.15		
31460	PERCUTANEOUS GASTROSTOMY TUBE, jejunal extension to, including any associated imaging services (Anaes.) (Assist.) Fee: \$289.45 Benefit: 75% = \$217.10 85% = \$246.05		
31462	OPERATIVE FEEDING JEJUNOSTOMY performed in conjunction with major upper gastro-intestinal resection (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50		
31464	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, by laparoscopic technique - not being a service to which item 30601 applies (Anaes.) (Assist.) (See para T8.19 of explanatory notes to this Category) Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35		
31466	ANTIREFLUX OPERATION BY FUNDOPLASTY, via abdominal or thoracic approach, with or without closure of the diaphragmatic hiatus, revision procedure, by laparoscopy or open operation (Anaes.) (Assist.) (See para T8.19 of explanatory notes to this Category) Fee: \$1,059.65 Benefit: 75% = \$794.75 85% = \$1,002.55		
31468	PARA-OESOPHAGEAL HIATUS HERNIA, repair of, with complete reduction of hernia, resection of sac and repair of hiatus, with or without fundoplication (Anaes.) (Assist.) Fee: \$1,164.20 Benefit: 75% = \$873.15 85% = \$1,107.10		
31470	LAPAROSCOPIC SPLENECTOMY (Anaes.) (Assist.) Fee: \$583.95 Benefit: 75% = \$438.00 85% = \$526.85		

OPERATIONS		GENERAL
31472	CHOLECYSTODUODENOSTOMY, CHOLECYSTOENTEROSTOMY, CHOLEDOCHOJEJUNOSTOMY OR ROUX-EN-Y as a bypass procedure where prior biliary surgery has been performed (Anaes.) (Assist.) Fee: \$948.50 Benefit: 75% = \$711.40 85% = \$891.40	
* 31500	BREAST, BENIGN LESION up to and including 50mm in diameter, including simple cyst, fibroadenoma or fibrocystic disease, open surgical biopsy or excision of, with or without frozen section histolog, not being a service to which items 31539 , 31542 or 31545 apply (Anaes.) (See para T8.23 of explanatory notes to this Category) Fee: \$210.85 Benefit: 75% = \$158.15 85% = \$179.25	
* 31503	BREAST, BENIGN LESION more than 50mm in diameter, excision of, not being a service to which items 31539 , 31542 or 31545 apply (Anaes.) (Assist.) (See para T8.23 of explanatory notes to this Category) Fee: \$281.15 Benefit: 75% = \$210.90 85% = \$239.00	
* 31506	BREAST, ABNORMALITY detected by mammography or ultrasound where guidewire or other localisation procedure is performed, excision biopsy of, not being a service to which items 31539 , 31542 or 31545 apply (Anaes.) (Assist.) (See para T8.23 of explanatory notes to this Category) Fee: \$316.30 Benefit: 75% = \$237.25 85% = \$268.90	
* 31509	BREAST, MALIGNANT TUMOUR, open surgical biopsy of, with or without frozen section histology, not being a service to which items 31539 , 31542 or 31545 apply (Anaes.) (See para T8.23 of explanatory notes to this Category) Fee: \$281.15 Benefit: 75% = \$210.90 85% = \$239.00	
* 31512	BREAST, MALIGNANT TUMOUR, complete local excision of, with or without frozen section histology, not being a service to which items 31539 , 31542 or 31545 apply (Anaes.) (Assist.) (See para T8.23 of explanatory notes to this Category) Fee: \$527.15 Benefit: 75% = \$395.40 85% = \$470.05	
* 31515	BREAST, TUMOUR SITE, re-excision of following open biopsy or incomplete excision of malignant tumour, not being a service to which items 31539 , 31542 or 31545 apply (Anaes.) (Assist.) (See para T8.23 of explanatory notes to this Category) Fee: \$353.60 Benefit: 75% = \$265.20 85% = \$300.60	
* 31518	BREAST (female), total mastectomy (Anaes.) (Assist.) Fee: \$596.95 Benefit: 75% = \$447.75 85% = \$539.85	
* 31521	BREAST (male), total mastectomy (Anaes.) (Assist.) Fee: \$351.45 Benefit: 75% = \$263.60 85% = \$298.75	
* 31524	BREAST (female), subcutaneous mastectomy (Anaes.) (Assist.) (See para T8.24 of explanatory notes to this Category) Fee: \$843.45 Benefit: 75% = \$632.60 85% = \$786.35	
* 31527	BREAST (male), subcutaneous mastectomy (Anaes.) (Assist.) (See para T8.24 of explanatory notes to this Category) Fee: \$421.75 Benefit: 75% = \$316.35 85% = \$364.65	
* 31530	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using a vacuum-assisted breast biopsy device under imaging guidance, for histological examination, where imaging has demonstrated: (a) microcalcification of lesion; or (b) palpable lesion less than 1cm in diameter - including pre-operative localisation of lesion where performed, not being a service to which items 31539 , 31545 or 31548 apply Fee: \$482.95 Benefit: 75% = \$362.25 85% = \$425.85	
* 31533	FINE NEEDLE ASPIRATION of an palpable breast lesion detected by mammography or ultrasound, imaging guided - but not including imaging (Anaes.) (See para T8.25 of explanatory notes to this Category) Fee: \$111.80 Benefit: 75% = \$83.85 85% = \$95.05	
* 31536	BREAST, preoperative localisation of lesion of, by hookwire or similar device, using interventional imaging techniques - but not including imaging, not being a service to which item 31542 applies (Anaes.) Fee: \$153.55 Benefit: 75% = \$115.20 85% = \$130.55	

OPERATIONS		COLORECTAL	
31539	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using Advanced Breast Biopsy Instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, not being a service to which items 31530 or 31536 apply (Anaes.) (See para T8.26 of explanatory notes to this Category)	Fee: \$323.35	Benefit: 75% = \$242.55 85% = \$274.85
31542	BREAST, initial guidewire localisation of lesion, by hookwire, when conducted by a radiologist as determined by the Royal Australian and New Zealand College of Radiologists, using interventional imaging techniques prior to Advanced Breast Biopsy Instrumentation (ABBI), - including imaging not being a service to which item 31536 applies (Anaes.) (See para T8.27 of explanatory notes to this Category)	Fee: \$159.60	Benefit: 75% = \$119.70 85% = \$135.70
31545	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using Advanced Breast Biopsy Instrumentation (ABBI), for histological examination, when conducted by a surgeon as determined by the Royal Australasian College of Surgeons, and where imaging has demonstrated an impalpable lesion of less than 15mm in diameter, including initial guidewire localisation of lesion, by hookwire, using interventional imaging techniques and including imaging not being a service to which item 31530 , 31536 or 31548 apply (Anaes.) (See para T8.26 of explanatory notes to this Category)	Fee: \$482.95	Benefit: 75% = \$362.25 85% = \$425.85
* 31548	BREAST, BIOPSY OF SOLID TUMOUR OR TISSUE OF, using mechanical biopsy device, for histological examination, not being a service to which items 31530, 31539 or 31545 apply (Anaes.)	Fee: \$111.80	Benefit: 75% = \$83.85 85% = \$95.05
* 31551	BREAST, HAEMATOMA, SEROMA OR INFLAMMATORY CONDITION including abscess, granulomatous mastitis or similar, exploration and drainage of when undertaken in the operating theatre of a hospital or day-hospital facility, excluding aftercare (Anaes.)	Fee: \$175.70	Benefit: 75% = \$131.80 85% = \$149.35
* 31554	BREAST, microdochotomy of, for benign or malignant condition (Anaes.) (Assist.)	Fee: \$351.45	Benefit: 75% = \$263.60 85% = \$298.75
* 31557	BREAST CENTRAL DUCTS, excision of, for benign condition (Anaes.) (Assist.)	Fee: \$281.15	Benefit: 75% = \$210.90 85% = \$239.00
* 31560	ACCESSORY BREAST TISSUE, excision of (Anaes.) (Assist.)	Fee: \$281.15	Benefit: 75% = \$210.90 85% = \$239.00
* 31563	INVERTED NIPPLE, surgical eversion of (Anaes.)	Fee: \$210.65	Benefit: 75% = \$158.00 85% = \$179.10
* 31566	ACCESSORY NIPPLE, excision of (Anaes.)	Fee: \$105.40	Benefit: 75% = \$79.05 85% = \$89.60
SUBGROUP 2 - COLORECTAL			
32000	LARGE INTESTINE, resection of, without anastomosis, including right hemicolectomy (including formation of stoma) (Anaes.) (Assist.)	Fee: \$836.20	Benefit: 75% = \$627.15 85% = \$779.10
32003	LARGE INTESTINE, resection of, with anastomosis, including right hemicolectomy (Anaes.) (Assist.)	Fee: \$874.75	Benefit: 75% = \$656.10 85% = \$817.65
32004	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) without anastomosis, not being a service associated with a service to which item 32000 , 32003 , 32005 or 32006 applies (Anaes.) (Assist.)	Fee: \$932.70	Benefit: 75% = \$699.55 85% = \$875.60
32005	LARGE INTESTINE, subtotal colectomy (resection of right colon, transverse colon and splenic flexure) with anastomosis, not being a service associated with a service to which item 32000, 32003, 32004 or 32006 applies (Anaes.) (Assist.)	Fee: \$1,053.65	Benefit: 75% = \$790.25 85% = \$996.55
32006	LEFT HEMICOLECTOMY, including the descending and sigmoid colon (including formation of stoma) (Anaes.) (Assist.)	Fee: \$932.70	Benefit: 75% = \$699.55 85% = \$875.60
32009	TOTAL COLECTOMY AND ILEOSTOMY (Anaes.) (Assist.)	Fee: \$1,106.40	Benefit: 75% = \$829.80 85% = \$1,049.30

OPERATIONS		COLORECTAL
32012	TOTAL COLECTOMY AND ILEORECTAL ANASTOMOSIS (Anaes.) (Assist.) Fee: \$1,222.15 Benefit: 75% = \$916.65 85% = \$1,165.05	
32015	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY 1 surgeon (Anaes.) (Assist.) Fee: \$1,501.95 Benefit: 75% = \$1,126.50 85% = \$1,444.85	
32018	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; ABDOMINAL RESECTION (including aftercare) (Anaes.) (Assist.) Fee: \$1,273.55 Benefit: 75% = \$955.20 85% = \$1,216.45	
32021	TOTAL COLECTOMY WITH EXCISION OF RECTUM AND ILEOSTOMY, COMBINED SYNCHRONOUS OPERATION; PERINEAL RESECTION (Assist.) Fee: \$456.70 Benefit: 75% = \$342.55 85% = \$399.60	
32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone (Anaes.) (Assist.) Fee: \$1,106.40 Benefit: 75% = \$829.80 85% = \$1,049.30	
32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma (Anaes.) (Assist.) Fee: \$1,479.90 Benefit: 75% = \$1,109.95 85% = \$1,422.80	
32026	RECTUM, ULTRA LOW RESTORATIVE RESECTION, with or without covering stoma, where the anastomosis is sited in the anorectal region and is 6cm or less from the anal verge (Anaes.) (Assist.) Fee: \$1,593.70 Benefit: 75% = \$1,195.30 85% = \$1,536.60	
32028	RECTUM, LOW OR ULTRA LOW RESTORATIVE RESECTION, with peranal sutured coloanal anastomosis, with or without covering stoma (Anaes.) (Assist.) Fee: \$1,707.60 Benefit: 75% = \$1,280.70 85% = \$1,650.50	
32029	COLONIC RESERVOIR, construction of, being a service associated with a service to which any other item in this Subgroup applies (Anaes.) (Assist.) Fee: \$341.50 Benefit: 75% = \$256.15 85% = \$290.30	
32030	RECTOSIGMOIDECTOMY (Hartmann's operation) (Anaes.) (Assist.) Fee: \$836.20 Benefit: 75% = \$627.15 85% = \$779.10	
32033	RESTORATION OF BOWEL following Hartmann's or similar operation, including dismantling of the stoma (Anaes.) (Assist.) Fee: \$1,222.15 Benefit: 75% = \$916.65 85% = \$1,165.05	
32036	SACROCOCCYGEAL AND PRESACRAL TUMOUR excision of (Anaes.) (Assist.) Fee: \$1,550.10 Benefit: 75% = \$1,162.60 85% = \$1,493.00	
32039	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF 1 surgeon (Anaes.) (Assist.) Fee: \$1,244.60 Benefit: 75% = \$933.45 85% = \$1,187.50	
32042	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION abdominal resection (Anaes.) (Assist.) Fee: \$1,048.45 Benefit: 75% = \$786.35 85% = \$991.35	
32045	RECTUM AND ANUS, ABDOMINOPERINEAL RESECTION OF, COMBINED SYNCHRONOUS OPERATION perineal resection (Assist.) Fee: \$392.40 Benefit: 75% = \$294.30 85% = \$335.30	
32046	RECTUM and ANUS, abdomino-perineal resection of, combined synchronous operation - perineal resection where the perineal surgeon also provides assistance to the abdominal surgeon (Assist.) Fee: \$606.35 Benefit: 75% = \$454.80 85% = \$549.25	
32047	PERINEAL PROCTECTOMY (Anaes.) (Assist.) Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35	
32051	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy 1 surgeon (Anaes.) (Assist.) Fee: \$1,878.25 Benefit: 75% = \$1,408.70 85% = \$1,821.15	

OPERATIONS	COLORECTAL
32054	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir, with or without creation of temporary ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,723.85 Benefit: 75% = \$1,292.90 85% = \$1,666.75
32057	TOTAL COLECTOMY with excision of rectum and ileoanal anastomosis with formation of ileal reservoir conjoint surgery, perineal surgeon (Assist.) Fee: \$456.70 Benefit: 75% = \$342.55 85% = \$399.60
32060	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy 1 surgeon (Anaes.) (Assist.) Fee: \$1,878.25 Benefit: 75% = \$1,408.70 85% = \$1,821.15
32063	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, abdominal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$1,723.85 Benefit: 75% = \$1,292.90 85% = \$1,666.75
32066	ILEOSTOMY CLOSURE with rectal resection and mucosectomy and ileoanal anastomosis with formation of ileal reservoir, with or without temporary loop ileostomy conjoint surgery, perineal surgeon (Assist.) Fee: \$456.70 Benefit: 75% = \$342.55 85% = \$399.60
32069	ILEOSTOMY RESERVOIR, continent type, creation of, including conversion of existing ileostomy where appropriate (Anaes.) Fee: \$1,389.40 Benefit: 75% = \$1,042.05 85% = \$1,332.30
32072	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), with or without biopsy Fee: \$38.85 Benefit: 75% = \$29.15 85% = \$33.05
32075	SIGMOIDOSCOPIC EXAMINATION (with rigid sigmoidoscope), UNDER GENERAL ANAESTHESIA, with or without biopsy, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$60.90 Benefit: 75% = \$45.70 85% = \$51.80
32078	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is less than or equal to 45 minutes (Anaes.) Fee: \$136.65 Benefit: 75% = \$102.50 85% = \$116.20
32081	SIGMOIDOSCOPIC EXAMINATION with diathermy OR resection of 1 or more polyps where the time taken is greater than 45 minutes (Anaes.) Fee: \$187.65 Benefit: 75% = \$140.75 85% = \$159.55
32084	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure, WITH or WITHOUT BIOPSY (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$90.30 Benefit: 75% = \$67.75 85% = \$76.80
32087	FLEXIBLE FIBREOPTIC SIGMOIDOSCOPY or FIBREOPTIC COLONOSCOPY up to the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS not being a service to which item 32078 applies (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$166.00 Benefit: 75% = \$124.50 85% = \$141.10
32090	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH or WITHOUT BIOPSY (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$271.00 Benefit: 75% = \$203.25 85% = \$230.35
32093	FIBREOPTIC COLONOSCOPY examination of colon beyond the hepatic flexure WITH REMOVAL OF 1 OR MORE POLYPS (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$380.40 Benefit: 75% = \$285.30 85% = \$323.35
32094	ENDOSCOPIC DILATATION OF COLORECTAL STRICTURES including colonoscopy (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$447.35 Benefit: 75% = \$335.55 85% = \$390.25
32095	ENDOSCOPIC EXAMINATION of SMALL BOWEL with flexible endoscope passed by stoma, with or without biopsies (Anaes.) <i>(See para T8.17 of explanatory notes to this Category)</i> Fee: \$103.65 Benefit: 75% = \$77.75 85% = \$88.15

OPERATIONS		COLORECTAL
32147	PERIANAL THROMBOSIS, incision of (Anaes.) Fee: \$36.60 Benefit: 75% = \$27.45 85% = \$31.15	
32150	OPERATION FOR FISSURE IN ANO, including excision or sphincterotomy, but excluding dilatation only (Anaes.) (Assist.) Fee: \$208.35 Benefit: 75% = \$156.30 85% = \$177.10	
32153	ANUS, DILATATION OF, under general anaesthesia, with or without disimpaction of faeces, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$56.90 Benefit: 75% = \$42.70 85% = \$48.40	
32156	FISTULA-IN-ANO, SUBCUTANEOUS, excision of (Anaes.) Fee: \$106.80 Benefit: 75% = \$80.10 85% = \$90.80	
32159	ANAL FISTULA, excision of, involving lower half of the anal sphincter mechanism (Anaes.) (Assist.) Fee: \$270.20 Benefit: 75% = \$202.65 85% = \$229.70	
32162	ANAL FISTULA, excision of, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.) Fee: \$392.40 Benefit: 75% = \$294.30 85% = \$335.30	
32165	ANAL FISTULA, repair of, by mucosal flap advancement (Anaes.) (Assist.) Fee: \$514.55 Benefit: 75% = \$385.95 85% = \$457.45	
32166	ANAL FISTULA - readjustment of Seton (Anaes.) Fee: \$167.15 Benefit: 75% = \$125.40 85% = \$142.10	
32168	FISTULA WOUND, review of, under general or regional anaesthetic, as an independent procedure (Anaes.) Fee: \$106.80 Benefit: 75% = \$80.10 85% = \$90.80	
32171	ANORECTAL EXAMINATION, with or without biopsy, under general anaesthetic, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$72.00 Benefit: 75% = \$54.00 85% = \$61.20	
32174	INTR-AANAL, perianal or ischiorectal abscess, drainage of (excluding aftercare) (Anaes.) Fee: \$72.00 Benefit: 75% = \$54.00 85% = \$61.20	
32175	INTRA-ANAL, PERIANAL or ISCHIO-RECTAL ABSCESS, draining of, undertaken in the operating theatre of a hospital or approved day-hospital facility (excluding aftercare) (Anaes.) Fee: \$131.85 Benefit: 75% = \$98.90 85% = \$112.10	
32177	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) Fee: \$141.30 Benefit: 75% = \$106.00 85% = \$120.15	
32180	ANAL WARTS, removal of, under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 35507 or 35508 applies (Anaes.) Fee: \$208.35 Benefit: 75% = \$156.30 85% = \$177.10	
32183	INTESTINAL SLING PROCEDURE prior to radiotherapy (Anaes.) (Assist.) Fee: \$455.40 Benefit: 75% = \$341.55 85% = \$398.30	
32186	COLONIC LAVAGE, total, intra operative (Anaes.) (Assist.) Fee: \$455.40 Benefit: 75% = \$341.55 85% = \$398.30	
32200	DISTAL MUSCLE, devascularisation of (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
32203	ANAL OR PERINEAL GRACILOPLASTY (Anaes.) (Assist.) Fee: \$514.80 Benefit: 75% = \$386.10 85% = \$457.70	
32206	STIMULATOR AND ELECTRODES, insertion of, following previous graciloplasty (Anaes.) (Assist.) Fee: \$465.10 Benefit: 75% = \$348.85 85% = \$408.00	
32209	ANAL OR PERINEAL GRACILOPLASTY with insertion of stimulator and electrodes (Anaes.) (Assist.) Fee: \$747.45 Benefit: 75% = \$560.60 85% = \$690.35	

OPERATIONS		VASCULAR
32210	GRACILIS NEOSPINCTER PACEMAKER, replacement of (Anaes.) Fee: \$207.10 Benefit: 75% = \$155.35 85% = \$176.05	
32212	ANO-RECTAL APPLICATION OF FORMALIN in the treatment of radiation proctitis, where performed in the operating theatre of a hospital or approved day-hospital facility, excluding aftercare (Anaes.) Fee: \$110.45 Benefit: 75% = \$82.85 85% = \$93.90	
SUBGROUP 3 - VASCULAR		
VARICOSE VEINS		
32500	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg (excluding after-care) - to a maximum of 6 treatments in a 12 month period (Anaes.) <i>(See para T8.28 of explanatory notes to this Category)</i> Fee: \$89.00 Benefit: 75% = \$66.75 85% = \$75.65	
32501	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections using continuous compression techniques, including associated consultation - 1 or both legs - not being a service associated with any other varicose vein operation on the same leg, (excluding after-care) - where it can be demonstrated that a 7th or subsequent treatment (including any treatments to which item 32500 applies) is indicated in a 12 month period <i>(See para T8.28 of explanatory notes to this Category)</i> Fee: \$89.00 Benefit: 75% = \$66.75 85% = \$75.65	
32504	VARICOSE VEINS, multiple excision of tributaries, with or without division of 1 or more perforating veins - 1 leg - not being a service associated with a service to which item 32507 , 32508 , 32511 , 32514 or 32517 applies on the same leg (Anaes.) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
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 on the same leg (Anaes.) (Assist.) Fee: \$432.65 Benefit: 75% = \$324.50 85% = \$375.55	
32508	VARICOSE VEINS, complete dissection at the sapheno-femoral OR sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) Fee: \$432.65 Benefit: 75% = \$324.50 85% = \$375.55	
32511	VARICOSE VEINS, complete dissection at the sapheno-femoral AND sapheno-popliteal junction - 1 leg - with or without either ligation or stripping, or both, of the long or short saphenous veins, for the first time on the same leg, including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) Fee: \$643.20 Benefit: 75% = \$482.40 85% = \$586.10	
32514	VARICOSE VEINS, ligation of the long or short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in the same territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) Fee: \$751.40 Benefit: 75% = \$563.55 85% = \$694.30	
32517	VARICOSE VEINS, ligation of the long and short saphenous vein on the same leg, with or without stripping, by re-operation for recurrent veins in either territory - 1 leg - including excision or injection of either tributaries or incompetent perforating veins, or both (Anaes.) (Assist.) Fee: \$967.55 Benefit: 75% = \$725.70 85% = \$910.45	
BYPASS OR ANASTOMOSIS FOR OCCLUSIVE ARTERIAL DISEASE		
32700	ARTERY OF NECK, bypass using vein or synthetic material (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45 85% = \$1,107.45	
32703	INTERNAL CAROTID ARTERY, transection and reanastomosis of, or resection of small length and reanastomosis of - with or without endarterectomy (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25	
32708	AORTIC BYPASS for occlusive disease using a straight non-bifurcated graft (Anaes.) (Assist.) Fee: \$1,152.40 Benefit: 75% = \$864.30 85% = \$1,095.30	
32710	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the iliac arteries (Anaes.) (Assist.) Fee: \$1,280.50 Benefit: 75% = \$960.40 85% = \$1,223.40	

OPERATIONS		VASCULAR	
32711	AORTIC BYPASS for occlusive disease using a bifurcated graft with 1 or both anastomoses to the common femoral or profunda femoris arteries (Anaes.) (Assist.) Fee: \$1,408.55 Benefit: 75% = \$1,056.45 85% = \$1,351.45		
32712	ILIO-FEMORAL BYPASS GRAFTING (Anaes.) (Assist.) Fee: \$1,018.25 Benefit: 75% = \$763.70 85% = \$961.15		
32715	AXILLARY or SUBCLAVIAN TO FEMORAL BYPASS GRAFTING to 1 or both FEMORAL ARTERIES (Anaes.) (Assist.) Fee: \$1,018.25 Benefit: 75% = \$763.70 85% = \$961.15		
32718	FEMORO-FEMORAL OR ILIO-FEMORAL CROSS-OVER BYPASS GRAFTING (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25		
32721	RENAL ARTERY, bypass grafting to (Anaes.) (Assist.) Fee: \$1,530.20 Benefit: 75% = \$1,147.65 85% = \$1,473.10		
32724	RENAL ARTERIES (both), bypass grafting to (Anaes.) (Assist.) Fee: \$1,737.60 Benefit: 75% = \$1,303.20 85% = \$1,680.50		
32730	MESENTERIC VESSEL (single), bypass grafting to (Anaes.) (Assist.) Fee: \$1,316.95 Benefit: 75% = \$987.75 85% = \$1,259.85		
32733	MESENTERIC VESSELS (multiple), bypass grafting to (Anaes.) (Assist.) Fee: \$1,530.20 Benefit: 75% = \$1,147.65 85% = \$1,473.10		
32736	INFERIOR MESENTERIC ARTERY, operation on, when performed in conjunction with another intra-abdominal vascular operation (Anaes.) (Assist.) Fee: \$335.30 Benefit: 75% = \$251.50 85% = \$285.05		
32739	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with above knee anastomosis (Anaes.) (Assist.) Fee: \$1,048.70 Benefit: 75% = \$786.55 85% = \$991.60		
32742	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to below knee popliteal artery (Anaes.) (Assist.) Fee: \$1,201.15 Benefit: 75% = \$900.90 85% = \$1,144.05		
32745	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis to tibio peroneal trunk or tibial or peroneal artery (Anaes.) (Assist.) Fee: \$1,371.75 Benefit: 75% = \$1,028.85 85% = \$1,314.65		
32748	FEMORAL ARTERY BYPASS GRAFTING using vein, including harvesting of vein (when it is the ipsilateral long saphenous vein) with distal anastomosis within 5cms of the ankle joint (Anaes.) (Assist.) Fee: \$1,487.65 Benefit: 75% = \$1,115.75 85% = \$1,430.55		
32751	FEMORAL ARTERY BYPASS GRAFTING using synthetic graft, with lower anastomosis above or below the knee (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25		
32754	FEMORAL ARTERY BYPASS GRAFTING, using a composite graft (synthetic material and vein) with lower anastomosis above or below the knee, including use of a cuff or sleeve of vein at 1 or both anastomoses (Anaes.) (Assist.) Fee: \$1,201.15 Benefit: 75% = \$900.90 85% = \$1,144.05		
32757	FEMORAL ARTERY SEQUENTIAL BYPASS GRAFTING, (using a vein or synthetic material) where an additional anastomosis is made to separately revascularise more than 1 artery - each additional artery revascularised beyond a femoral bypass (Anaes.) (Assist.) Fee: \$335.30 Benefit: 75% = \$251.50 85% = \$285.05		
32760	VEIN, HARVESTING OF, FROM LEG OR ARM for bypass or replacement graft when not performed on the limb which is the subject of the bypass or graft - each vein (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80		
32763	ARTERIAL BYPASS GRAFTING, using vein or synthetic material, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25		

OPERATIONS		VASCULAR
32766	ARTERIAL OR VENOUS ANASTOMOSIS, not being a service to which another item in this Sub-group applies, as an independent procedure (Anaes.) (Assist.) Fee: \$640.20 Benefit: 75% = \$480.15 85% = \$583.10	
32769	ARTERIAL OR VENOUS ANASTOMOSIS not being a service to which another item in this Sub-group applies, when performed in combination with another vascular operation (including graft to graft anastomosis) (Anaes.) (Assist.) Fee: \$221.90 Benefit: 75% = \$166.45 85% = \$188.65	
BYPASS, REPLACEMENT, LIGATION OF ANEURYSMS		
33050	BYPASS GRAFTING to replace a popliteal aneurysm using vein, including harvesting vein (when it is the ipsilateral long saphenous vein) (Anaes.) (Assist.) Fee: \$1,179.90 Benefit: 75% = \$884.95 85% = \$1,122.80	
33055	BYPASS GRAFTING to replace a popliteal aneurysm using a synthetic graft (Anaes.) (Assist.) Fee: \$946.25 Benefit: 75% = \$709.70 85% = \$889.15	
33070	ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$682.70 Benefit: 75% = \$512.05 85% = \$625.60	
33075	ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$868.45 Benefit: 75% = \$651.35 85% = \$811.35	
33080	INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,060.05 Benefit: 75% = \$795.05 85% = \$1,002.95	
33100	ANEURYSM OF COMMON OR INTERNAL CAROTID ARTERY, OR BOTH, replacement by graft of vein or synthetic material (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45 85% = \$1,107.45	
33103	THORACIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$1,633.90 Benefit: 75% = \$1,225.45 85% = \$1,576.80	
33109	THORACO-ABDOMINAL ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) Fee: \$1,975.45 Benefit: 75% = \$1,481.60 85% = \$1,918.35	
33112	SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft including re-implantation of arteries (Anaes.) (Assist.) Fee: \$1,713.20 Benefit: 75% = \$1,284.90 85% = \$1,656.10	
33115	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft, not being a service associated with a service to which item 33116 applies (Anaes.) (Assist.) Fee: \$1,152.40 Benefit: 75% = \$864.30 85% = \$1,095.30	
+ 33116	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.) (Assist.) <i>(See para T8.29 of explanatory notes to this Category)</i> Fee: \$1,134.25 Benefit: 75% = \$850.70 85% = \$1,077.15	
33118	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision of common iliac aneurysms) not being a service associated with a service to which item 33119 applies (Anaes.) (Assist.) Fee: \$1,280.50 Benefit: 75% = \$960.40 85% = \$1,223.40	
+ 33119	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to one or both iliac arteries using endovascular repair procedure, excluding associated radiological services (Ministerial Determination) (Anaes.) (Assist.) <i>(See para T8.29 of explanatory notes to this Category)</i> Fee: \$1,260.35 Benefit: 75% = \$945.30 85% = \$1,203.25	
33121	INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) Fee: \$1,408.55 Benefit: 75% = \$1,056.45 85% = \$1,351.45	
33124	ANEURYSM OF ILIAC ARTERY (common, external or internal), replacement by graft - unilateral (Anaes.) (Assist.) Fee: \$981.60 Benefit: 75% = \$736.20 85% = \$924.50	

OPERATIONS		VASCULAR	
33127	ANEURYSMS OF ILIAC ARTERIES (common, external or internal), replacement by graft - bilateral (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35		
33130	ANEURYSM OF VISCERAL ARTERY, excision and repair by direct anastomosis or replacement by graft (Anaes.) (Assist.) Fee: \$1,121.80 Benefit: 75% = \$841.35 85% = \$1,064.70		
33133	ANEURYSM OF VISCERAL ARTERY, dissection and ligation of arteries without restoration of continuity (Anaes.) (Assist.) Fee: \$841.35 Benefit: 75% = \$631.05 85% = \$784.25		
33136	FALSE ANEURYSM, repair of, at aortic anastomosis following previous aortic surgery (Anaes.) (Assist.) Fee: \$2,121.65 Benefit: 75% = \$1,591.25 85% = \$2,064.55		
33139	FALSE ANEURYSM, repair of, in iliac artery and restoration of arterial continuity (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35		
33142	FALSE ANEURYSM, repair of, in femoral artery and restoration of arterial continuity (Anaes.) (Assist.) Fee: \$1,201.15 Benefit: 75% = \$900.90 85% = \$1,144.05		
33145	RUPTURED THORACIC AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,066.85 Benefit: 75% = \$1,550.15 85% = \$2,009.75		
33148	RUPTURED THORACO-ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,566.80 Benefit: 75% = \$1,925.10 85% = \$2,509.70		
33151	RUPTURED SUPRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$2,438.75 Benefit: 75% = \$1,829.10 85% = \$2,381.65		
33154	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by tube graft (Anaes.) (Assist.) Fee: \$1,804.75 Benefit: 75% = \$1,353.60 85% = \$1,747.65		
33157	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to iliac arteries (with or without excision or bypass of common iliac aneurysms) (Anaes.) (Assist.) Fee: \$2,011.95 Benefit: 75% = \$1,509.00 85% = \$1,954.85		
33160	RUPTURED INFRARENAL ABDOMINAL AORTIC ANEURYSM, replacement by bifurcation graft to 1 or both femoral arteries (Anaes.) (Assist.) Fee: \$2,011.95 Benefit: 75% = \$1,509.00 85% = \$1,954.85		
33163	RUPTURED ILIAC ARTERY ANEURYSM, replacement by graft (Anaes.) (Assist.) Fee: \$1,707.25 Benefit: 75% = \$1,280.45 85% = \$1,650.15		
33166	RUPTURED ANEURYSM OF VISCERAL ARTERY, replacement by anastomosis or graft (Anaes.) (Assist.) Fee: \$1,707.25 Benefit: 75% = \$1,280.45 85% = \$1,650.15		
33169	RUPTURED ANEURYSM OF VISCERAL ARTERY, simple ligation of (Anaes.) (Assist.) Fee: \$1,329.15 Benefit: 75% = \$996.90 85% = \$1,272.05		
33172	ANEURYSM OF MAJOR ARTERY, replacement by graft, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$1,036.45 Benefit: 75% = \$777.35 85% = \$979.35		
33175	RUPTURED ANEURYSM IN THE EXTREMITIES, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$955.20 Benefit: 75% = \$716.40 85% = \$898.10		
33178	RUPTURED ANEURYSM IN THE NECK, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,214.70 Benefit: 75% = \$911.05 85% = \$1,157.60		
33181	RUPTURED INTRA-ABDOMINAL OR PELVIC ANEURYSM, ligation, suture closure or excision of, without bypass grafting (Anaes.) (Assist.) Fee: \$1,485.10 Benefit: 75% = \$1,113.85 85% = \$1,428.00		
	ENDARTERECTOMY AND ARTERIAL PATCH		
33500	ARTERY OR ARTERIES OF NECK, endarterectomy of, including closure by suture (where endarterectomy of 1 or more arteries is undertaken through 1 arteriotomy incision) (Anaes.) (Assist.) Fee: \$920.60 Benefit: 75% = \$690.45 85% = \$863.50		

OPERATIONS	VASCULAR
33506	INNOMINATE OR SUBCLAVIAN ARTERY, endarterectomy of, including closure by suture (Anaes.) (Assist.) Fee: \$1,030.45 Benefit: 75% = \$772.85 85% = \$973.35
33509	AORTIC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the aorta (Anaes.) (Assist.) Fee: \$1,152.40 Benefit: 75% = \$864.30 85% = \$1,095.30
33512	AORTO-ILIAC ENDARTERECTOMY (1 or both iliac arteries), including closure by suture not being a service associated with a service to which item 33515 applies (Anaes.) (Assist.) Fee: \$1,280.50 Benefit: 75% = \$960.40 85% = \$1,223.40
33515	AORTO-FEMORAL ENDARTERECTOMY (1 or both femoral arteries) or BILATERAL ILIO-FEMORAL ENDARTERECTOMY, including closure by suture, not being a service associated with a service to which item 33512 applies (Anaes.) (Assist.) Fee: \$1,408.55 Benefit: 75% = \$1,056.45 85% = \$1,351.45
33518	ILIAC ENDARTERECTOMY, including closure by suture, not being a service associated with another procedure on the iliac artery (Anaes.) (Assist.) Fee: \$1,030.45 Benefit: 75% = \$772.85 85% = \$973.35
33521	ILIO-FEMORAL ENDARTERECTOMY (1 side), including closure by suture (Anaes.) (Assist.) Fee: \$1,115.70 Benefit: 75% = \$836.80 85% = \$1,058.60
33524	RENAL ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,316.95 Benefit: 75% = \$987.75 85% = \$1,259.85
33527	RENAL ARTERIES (both), endarterectomy of (Anaes.) (Assist.) Fee: \$1,530.20 Benefit: 75% = \$1,147.65 85% = \$1,473.10
33530	COELIAC OR SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,316.95 Benefit: 75% = \$987.75 85% = \$1,259.85
33533	COELIAC AND SUPERIOR MESENTERIC ARTERY, endarterectomy of (Anaes.) (Assist.) Fee: \$1,530.20 Benefit: 75% = \$1,147.65 85% = \$1,473.10
33536	INFERIOR MESENTERIC ARTERY, endarterectomy of, not being a service associated with a service to which another other item in this Sub-group applies (Anaes.) (Assist.) Fee: \$1,091.40 Benefit: 75% = \$818.55 85% = \$1,034.30
33539	ARTERY OF EXTREMITIES, endarterectomy of, including closure by suture (Anaes.) (Assist.) Fee: \$786.50 Benefit: 75% = \$589.90 85% = \$729.40
33542	EXTENDED DEEP FEMORAL ENDARTERECTOMY where the endarterectomy is at least 7cms long (Anaes.) (Assist.) Fee: \$1,121.80 Benefit: 75% = \$841.35 85% = \$1,064.70
33545	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is less than 3cm long (Anaes.) (Assist.) <i>(See para T8.30 of explanatory notes to this Category)</i> Fee: \$221.90 Benefit: 75% = \$166.45 85% = \$188.65
33548	ARTERY, VEIN OR BYPASS GRAFT, patch grafting to by vein or synthetic material where patch is 3cm long or greater (Anaes.) (Assist.) <i>(See para T8.30 of explanatory notes to this Category)</i> Fee: \$451.30 Benefit: 75% = \$338.50 85% = \$394.20
33551	VEIN, harvesting of from leg or arm for patch when not performed through same incision as operation (Anaes.) (Assist.) <i>(See para T8.30 of explanatory notes to this Category)</i> Fee: \$221.90 Benefit: 75% = \$166.45 85% = \$188.65
33554	ENDARTERECTOMY, in conjunction with an arterial bypass operation to prepare the site for anastomosis - each site (Anaes.) (Assist.) Fee: \$220.85 Benefit: 75% = \$165.65 85% = \$187.75
	EMBOLECTOMY, THROMBECTOMY AND VASCULAR TRAUMA
33800	EMBOLUS, removal of, from artery of neck (Anaes.) (Assist.) Fee: \$957.20 Benefit: 75% = \$717.90 85% = \$900.10

OPERATIONS		VASCULAR	
33803	EMBOLECTOMY or THROMBECTOMY, by abdominal approach, of an artery or bypass graft of trunk (Anaes.) (Assist.) Fee: \$914.55 Benefit: 75% = \$685.95 85% = \$857.45		
33806	EMBOLECTOMY OR THROMBECTOMY, including the infusion of thrombolytic or other agents, from an artery or bypass graft of extremities, or embolectomy of abdominal artery via the femoral artery (Anaes.) (Assist.) <i>(See para T8.31 of explanatory notes to this Category)</i> Fee: \$658.50 Benefit: 75% = \$493.90 85% = \$601.40		
33810	INFERIOR VENA CAVA OR ILIAC VEIN, closed thrombectomy by catheter via the femoral vein (Anaes.) (Assist.) Fee: \$480.35 Benefit: 75% = \$360.30 85% = \$423.25		
33811	INFERIOR VENA CAVA OR ILIAC VEIN, open removal of thrombus or tumour (Anaes.) (Assist.) Fee: \$1,429.95 Benefit: 75% = \$1,072.50 85% = \$1,372.85		
33812	THROMBUS, removal of, from femoral or other similar large vein (Anaes.) (Assist.) Fee: \$756.05 Benefit: 75% = \$567.05 85% = \$698.95		
33815	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) Fee: \$695.05 Benefit: 75% = \$521.30 85% = \$637.95		
33818	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) Fee: \$810.95 Benefit: 75% = \$608.25 85% = \$753.85		
33821	MAJOR ARTERY OR VEIN OF EXTREMITY, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) Fee: \$926.75 Benefit: 75% = \$695.10 85% = \$869.65		
33824	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by lateral suture (Anaes.) (Assist.) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90		
33827	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by direct anastomosis (Anaes.) (Assist.) Fee: \$1,036.45 Benefit: 75% = \$777.35 85% = \$979.35		
33830	MAJOR ARTERY OR VEIN OF NECK, repair of wound of, with restoration of continuity, by interposition graft of synthetic material or vein (Anaes.) (Assist.) Fee: \$1,188.85 Benefit: 75% = \$891.65 85% = \$1,131.75		
33833	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by lateral suture (Anaes.) (Assist.) Fee: \$1,079.20 Benefit: 75% = \$809.40 85% = \$1,022.10		
33836	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by direct anastomosis (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35		
33839	MAJOR ARTERY OR VEIN OF ABDOMEN, repair of wound of, with restoration of continuity by means of interposition graft (Anaes.) (Assist.) Fee: \$1,505.95 Benefit: 75% = \$1,129.50 85% = \$1,448.85		
33842	ARTERY OF NECK, re-operation for bleeding or thrombosis after carotid or vertebral artery surgery (Anaes.) (Assist.) Fee: \$743.85 Benefit: 75% = \$557.90 85% = \$686.75		
33845	LAPAROTOMY for control of post operative bleeding or thrombosis after intra-abdominal vascular procedure, where no other procedure is performed (Anaes.) (Assist.) Fee: \$518.25 Benefit: 75% = \$388.70 85% = \$461.15		
33848	EXTREMITY, re-operation on, for control of bleeding or thrombosis after vascular procedure, where no other procedure is performed (Anaes.) (Assist.) Fee: \$518.25 Benefit: 75% = \$388.70 85% = \$461.15		

OPERATIONS	VASCULAR
	LIGATION, EXCISION, ELECTIVE REPAIR, DECOMPRESSION OF VESSELS
34100	MAJOR ARTERY OF NECK, elective ligation or exploration of, not being a service associated with any other vascular procedure (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90 85% = \$516.05
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.) (Assist.) Fee: \$335.30 Benefit: 75% = \$251.50 85% = \$285.05
34106	ARTERY OR VEIN (including brachial, radial, ulnar or tibial), ligation of, by elective operation, or exploration of, not being a service associated with any other vascular procedure except those services to which items 32508 , 32511 , 32514 or 32517 apply (Anaes.) (Assist.) Fee: \$236.55 Benefit: 75% = \$177.45 85% = \$201.10
34109	TEMPORAL ARTERY, biopsy of (Anaes.) (Assist.) Fee: \$274.30 Benefit: 75% = \$205.75 85% = \$233.20
34112	ARTERIO-VEINUS FISTULA OF AN EXTREMITY, dissection and ligation (Anaes.) (Assist.) Fee: \$695.05 Benefit: 75% = \$521.30 85% = \$637.95
34115	ARTERIO-VEINUS FISTULA OF THE NECK, dissection and ligation (Anaes.) (Assist.) Fee: \$786.50 Benefit: 75% = \$589.90 85% = \$729.40
34118	ARTERIO-VEINUS FISTULA OF THE ABDOMEN, dissection and ligation (Anaes.) (Assist.) Fee: \$1,121.80 Benefit: 75% = \$841.35 85% = \$1,064.70
34121	ARTERIO-VEINUS FISTULA OF AN EXTREMITY, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$896.20 Benefit: 75% = \$672.15 85% = \$839.10
34124	ARTERIO-VEINUS FISTULA OF THE NECK, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$981.60 Benefit: 75% = \$736.20 85% = \$924.50
34127	ARTERIO-VEINUS FISTULA OF THE ABDOMEN, dissection and repair of, with restoration of continuity (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35
34130	SURGICALLY CREATED ARTERIO-VEINUS FISTULA OF AN EXTREMITY, closure of (Anaes.) (Assist.) Fee: \$402.45 Benefit: 75% = \$301.85 85% = \$345.35
34133	SCALENOTOMY (Anaes.) (Assist.) Fee: \$451.30 Benefit: 75% = \$338.50 85% = \$394.20
34136	FIRST RIB, resection of portion of (Anaes.) (Assist.) Fee: \$725.45 Benefit: 75% = \$544.10 85% = \$668.35
34139	CERVICAL RIB, removal of, or other operation for removal of thoracic outlet compression, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$725.45 Benefit: 75% = \$544.10 85% = \$668.35
34142	COELIAC ARTERY, decompression of, for coeliac artery compression syndrome, as an independent procedure (Anaes.) (Assist.) Fee: \$896.20 Benefit: 75% = \$672.15 85% = \$839.10
34145	POPLITEAL ARTERY, exploration of, for popliteal entrapment, with or without division of fibrous tissue and muscle (Anaes.) (Assist.) Fee: \$652.40 Benefit: 75% = \$489.30 85% = \$595.30
34148	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.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45 85% = \$1,107.45
34151	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.) (Assist.) Fee: \$1,591.30 Benefit: 75% = \$1,193.50 85% = \$1,534.20

OPERATIONS		VASCULAR
34154	RECURRENT CAROTID ASSOCIATED TUMOUR, resection of, with or without repair or replacement of portion of internal or common carotid arteries (Anaes.) (Assist.) Fee: \$1,896.20 Benefit: 75% = \$1,422.15 85% = \$1,839.10	
34157	NECK, excision of infected bypass graft, including closure of vessel or vessels (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25	
34160	AORTO-DUODENAL FISTULA, repair of, by suture of aorta and repair of duodenum (Anaes.) (Assist.) Fee: \$1,804.75 Benefit: 75% = \$1,353.60 85% = \$1,747.65	
34163	AORTO-DUODENAL FISTULA, repair of, by insertion of aortic graft and repair of duodenum (Anaes.) (Assist.) Fee: \$2,316.85 Benefit: 75% = \$1,737.65 85% = \$2,259.75	
34166	AORTO-DUODENAL FISTULA, repair of, by oversewing of abdominal aorta, repair of duodenum and axillo-bifemoral grafting (Anaes.) (Assist.) Fee: \$2,316.85 Benefit: 75% = \$1,737.65 85% = \$2,259.75	
34169	INFECTED BYPASS GRAFT FROM TRUNK, excision of, including closure of arteries (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35	
34172	INFECTED AXILLO-FEMORAL OR FEMORO-FEMORAL GRAFT, excision of, including closure of arteries (Anaes.) (Assist.) Fee: \$1,048.70 Benefit: 75% = \$786.55 85% = \$991.60	
34175	INFECTED BYPASS GRAFT FROM EXTREMITIES, excision of including closure of arteries (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25	
OPERATIONS FOR VASCULAR ACCESS		
34500	ARTERIOVENOUS SHUNT, EXTERNAL, insertion of (Anaes.) (Assist.) Fee: \$250.00 Benefit: 75% = \$187.50 85% = \$212.50	
34503	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, in conjunction with another venous or arterial operation (Anaes.) (Assist.) Fee: \$335.30 Benefit: 75% = \$251.50 85% = \$285.05	
34506	ARTERIOVENOUS SHUNT, EXTERNAL, removal of (Anaes.) (Assist.) Fee: \$170.70 Benefit: 75% = \$128.05 85% = \$145.10	
34509	ARTERIOVENOUS ANASTOMOSIS OF UPPER OR LOWER LIMB, not in conjunction with another venous or arterial operation (Anaes.) (Assist.) Fee: \$792.60 Benefit: 75% = \$594.45 85% = \$735.50	
34512	ARTERIOVENOUS ACCESS DEVICE, insertion of (Anaes.) (Assist.) Fee: \$871.90 Benefit: 75% = \$653.95 85% = \$814.80	
34515	ARTERIOVENOUS ACCESS DEVICE, thrombectomy of (Anaes.) (Assist.) Fee: \$621.85 Benefit: 75% = \$466.40 85% = \$564.75	
34518	STENOSIS OF ARTERIOVENOUS FISTULA OR PROSTHETIC ARTERIOVENOUS ACCESS DEVICE, correction of (Anaes.) (Assist.) Fee: \$1,042.55 Benefit: 75% = \$781.95 85% = \$985.45	
34521	INTRA-ABDOMINAL ARTERY OR VEIN, cannulation of, for infusion chemotherapy, by open operation (excluding aftercare) (Anaes.) (Assist.) Fee: \$640.45 Benefit: 75% = \$480.35 85% = \$583.35	
34524	ARTERIAL CANNULATION for infusion chemotherapy by open operation, not being a service to which item 34521 applies (excluding after-care) (Anaes.) (Assist.) Fee: \$335.30 Benefit: 75% = \$251.50 85% = \$285.05	
34527	CENTRAL VEIN CATHETERISATION by <u>open technique</u> , using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device, including any associated percutaneous central vein catheterisation (Anaes.) Fee: \$447.20 Benefit: 75% = \$335.40 85% = \$390.10	

OPERATIONS		VASCULAR
34528	CENTRAL VEIN CATHETERISATION by percutaneous technique, using subcutaneous tunnel with pump or access port as with Hickman or Broviac catheter or other chemotherapy delivery device (Anaes.) Fee: \$220.85 Benefit: 75% = \$165.65 85% = \$187.75	
34530	HICKMAN OR BROVIAC CATHETER, OR OTHER CHEMOTHERAPY DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital (Anaes.) Fee: \$165.65 Benefit: 75% = \$124.25 85% = \$140.85	
34533	ISOLATED LIMB PERFUSION, including cannulation of artery and vein at commencement of procedure, regional perfusion for chemotherapy, or other therapy, repair of arteriotomy and venotomy at conclusion of procedure (excluding aftercare) (Anaes.) (Assist.) Fee: \$1,005.95 Benefit: 75% = \$754.50 85% = \$948.85	
COMPLEX VENOUS OPERATIONS		
34800	INFERIOR VENA CAVA, plication, ligation, or application of caval clip (Anaes.) (Assist.) Fee: \$658.50 Benefit: 75% = \$493.90 85% = \$601.40	
34803	INFERIOR VENA CAVA, reconstruction of or bypass by vein or synthetic material (Anaes.) (Assist.) Fee: \$1,451.10 Benefit: 75% = \$1,088.35 85% = \$1,394.00	
34806	CROSS LEG BYPASS GRAFTING, saphenous to iliac or femoral vein (Anaes.) (Assist.) Fee: \$786.50 Benefit: 75% = \$589.90 85% = \$729.40	
34809	SAPHENOUS VEIN ANASTOMOSIS to femoral or popliteal vein for femoral vein bypass (Anaes.) (Assist.) Fee: \$786.50 Benefit: 75% = \$589.90 85% = \$729.40	
34812	VENOUS STENOSIS OR OCCLUSION, vein bypass for, using vein or synthetic material, not being a service associated with a service to which item 34806 or 34809 applies (Anaes.) (Assist.) Fee: \$951.15 Benefit: 75% = \$713.40 85% = \$894.05	
34815	VEIN STENOSIS, patch angioplasty for, (excluding vein graft stenosis)-using vein or synthetic material (Anaes.) (Assist.) <i>(See para T8.30 of explanatory notes to this Category)</i> Fee: \$786.50 Benefit: 75% = \$589.90 85% = \$729.40	
34818	VENOUS VALVE, plication or repair to restore valve competency (Anaes.) (Assist.) Fee: \$865.75 Benefit: 75% = \$649.35 85% = \$808.65	
34821	VEIN TRANSPLANT to restore valvular function (Anaes.) (Assist.) Fee: \$1,176.75 Benefit: 75% = \$882.60 85% = \$1,119.65	
34824	EXTERNAL STENT, application of, to restore venous valve competency to superficial vein - 1 stent (Anaes.) (Assist.) Fee: \$402.45 Benefit: 75% = \$301.85 85% = \$345.35	
34827	EXTERNAL STENTS, application of, to restore venous valve competency to superficial vein or veins - more than 1 stent (Anaes.) (Assist.) Fee: \$487.75 Benefit: 75% = \$365.85 85% = \$430.65	
34830	EXTERNAL STENT, application of, to restore venous valve competency to deep vein (1 stent) (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90 85% = \$516.05	
34833	EXTERNAL STENTS, application of, to restore venous valve competency to deep vein or veins (more than 1 stent) (Anaes.) (Assist.) Fee: \$743.85 Benefit: 75% = \$557.90 85% = \$686.75	
SYMPATHECTOMY		
35000	LUMBAR SYMPATHECTOMY (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90 85% = \$516.05	
35003	CERVICAL OR UPPER THORACIC SYMPATHECTOMY by any surgical approach (Anaes.) (Assist.) Fee: \$743.85 Benefit: 75% = \$557.90 85% = \$686.75	
35006	CERVICAL OR UPPER THORACIC SYMPATHECTOMY, where operation is a reoperation for previous incomplete sympathectomy by any surgical approach (Anaes.) (Assist.) Fee: \$932.85 Benefit: 75% = \$699.65 85% = \$875.75	

OPERATIONS	VASCULAR
35009	LUMBAR SYMPATHECTOMY, where operation is following chemical sympathectomy or for previous incomplete surgical sympathectomy (Anaes.) (Assist.) Fee: \$725.45 Benefit: 75% = \$544.10 85% = \$668.35
35012	SACRAL or PRE-SACRAL SYMPATHECTOMY (Anaes.) (Assist.) Fee: \$573.15 Benefit: 75% = \$429.90 85% = \$516.05
DEBRIDEMENT AND AMPUTATIONS FOR VASCULAR DISEASE	
35100	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, when debridement includes muscle, tendon or bone (Anaes.) (Assist.) Fee: \$298.85 Benefit: 75% = \$224.15 85% = \$254.05
35103	ISCHAEMIC LIMB, debridement of necrotic material, gangrenous tissue, or slough in, in the operating theatre of a hospital, superficial tissue only (Anaes.) Fee: \$190.20 Benefit: 75% = \$142.65 85% = \$161.70
MISCELLANEOUS VASCULAR PROCEDURES	
35200	OPERATIVE ARTERIOGRAPHY OR VENOGRAPHY, 1 or more of, performed during the course of an operative procedure on an artery or vein, 1 site (Anaes.) Fee: \$139.05 Benefit: 75% = \$104.30 85% = \$118.20
35202	MAJOR ARTERIES OR VEINS IN THE NECK, ABDOMEN OR EXTREMITIES, access to, as part of RE-OPERATION after prior surgery on these vessels (Anaes.) (Assist.) Fee: \$662.55 Benefit: 75% = \$496.95 85% = \$605.45
ENDOVASCULAR INTERVENTIONAL PROCEDURES	
35300	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$417.90 Benefit: 75% = \$313.45 85% = \$360.80
35303	TRANSLUMINAL BALLOON ANGIOPLASTY of aortic arch branches, aortic visceral branches, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$535.75 Benefit: 75% = \$401.85 85% = \$478.65
35304	TRANSLUMINAL BALLOON ANGIOPLASTY of 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$417.90 Benefit: 75% = \$313.45 85% = \$360.80
35305	TRANSLUMINAL BALLOON ANGIOPLASTY of more than 1 coronary artery, percutaneous or by open exposure, excluding associated radiological services or preparation and excluding aftercare (Anaes.) (Assist.) Fee: \$535.75 Benefit: 75% = \$401.85 85% = \$478.65
35306	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$494.50 Benefit: 75% = \$370.90 85% = \$437.40
35309	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for visceral arteries or veins, or more than 1 peripheral artery or vein of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$618.15 Benefit: 75% = \$463.65 85% = \$561.05
35310	TRANSLUMINAL STENT INSERTION including associated balloon dilatation for coronary artery, percutaneous or by open exposure, excluding associated radiological services and preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$618.15 Benefit: 75% = \$463.65 85% = \$561.05
35312	PERIPHERAL ARTERIAL ATHERECTOMY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$700.55 Benefit: 75% = \$525.45 85% = \$643.45
35315	PERIPHERAL LASER ANGIOPLASTY including associated balloon dilatation of 1 limb, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) Fee: \$700.55 Benefit: 75% = \$525.45 85% = \$643.45

OPERATIONS		GYNAECOLOGICAL	
35317	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY CONTINUOUS INFUSION, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35319 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.) (See para T8.32 of explanatory notes to this Category)	Fee: \$288.50	Benefit: 75% = \$216.40 85% = \$245.25
35319	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY PULSE SPRAY TECHNIQUE, using percutaneous approach, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35320 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	Fee: \$517.10	Benefit: 75% = \$387.85 85% = \$460.00
35320	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION with administration of thrombolytic or chemotherapeutic agents, BY OPEN EXPOSURE, excluding associated radiological services or preparation, and excluding aftercare (not being a service associated with a service to which another item in Subgroup 11 of Group T1 or items 35317 or 35319 applies and not being a service associated with photodynamic therapy with verteporfin) (Anaes.) (Assist.)	Fee: \$694.65	Benefit: 75% = \$521.00 85% = \$637.55
35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.)	Fee: \$659.35	Benefit: 75% = \$494.55 85% = \$602.25
35324	ANGIOSCOPY not combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	Fee: \$247.20	Benefit: 75% = \$185.40 85% = \$210.15
35327	ANGIOSCOPY combined with any other procedure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	Fee: \$331.30	Benefit: 75% = \$248.50 85% = \$281.65
35330	INSERTION of INFERIOR VENA CAVAL FILTER, percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.)	Fee: \$417.90	Benefit: 75% = \$313.45 85% = \$360.80
SUBGROUP 4 - GYNAECOLOGICAL			
35500	GYNAECOLOGICAL EXAMINATION UNDER ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)	Fee: \$65.85	Benefit: 75% = \$49.40 85% = \$56.00
35503	INTRAUTERINE CONTRACEPTIVE DEVICE, INTRODUCTION OF, not being a service associated with a service to which another item in this Group applies (Anaes.)	Fee: \$43.40	Benefit: 75% = \$32.55 85% = \$36.90
35506	INTRAUTERINE CONTRACEPTIVE DEVICE, REMOVAL OF UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.)	Fee: \$43.50	Benefit: 75% = \$32.65 85% = \$37.00
35507	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is less than or equal to 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.)	Fee: \$141.50	Benefit: 75% = \$106.15 85% = \$120.30
35508	VULVAL OR VAGINAL WARTS, removal of under general anaesthesia, or under regional or field nerve block (excluding pudendal block) requiring admission to a hospital or approved day-hospital facility, where the time taken is greater than 45 minutes - not being a service associated with a service to which item 32177 or 32180 applies (Anaes.) (Assist.)	Fee: \$208.35	Benefit: 75% = \$156.30 85% = \$177.10
35509	HYMENECTOMY (Anaes.)	Fee: \$72.60	Benefit: 75% = \$54.45 85% = \$61.75
35512 G	BARTHOLIN'S CYST, excision of (Anaes.)	Fee: \$145.40	Benefit: 75% = \$109.05 85% = \$123.60
35513 S		Fee: \$179.80	Benefit: 75% = \$134.85 85% = \$152.85

OPERATIONS		GYNAECOLOGICAL	
35516 G 35517 S	BARTHOLIN'S CYST OR GLAND, marsupialisation of (Anaes.) Fee: \$94.35 Benefit: 75% = \$70.80	85% = \$80.20 85% = \$100.60	
35518	OVARIAN CYST ASPIRATION, for cysts of at least 4cm in diameter in premenopausal women and at least 2cm in diameter in postmenopausal women, by abdominal or vaginal route, using interventional imaging techniques and not associated with services provided for assisted reproductive techniques (Anaes.) Fee: \$168.45 Benefit: 75% = \$126.35	85% = \$143.20	
35520	BARTHOLIN'S ABSCESS, incision of (Anaes.) Fee: \$47.25 Benefit: 75% = \$35.45	85% = \$40.20	
35523	URETHRA OR URETHRAL CARUNCLE, cauterisation of (Anaes.) Fee: \$47.25 Benefit: 75% = \$35.45	85% = \$40.20	
35526 G 35527 S	URETHRAL CARUNCLE, excision of (Anaes.) Fee: \$94.35 Benefit: 75% = \$70.80	85% = \$80.20 85% = \$100.60	
35530	CLITORIS, amputation of, where medically indicated (Anaes.) (Assist.) Fee: \$218.75 Benefit: 75% = \$164.10	85% = \$185.95	
35533	VULVOPLASTY or LABIOPLASTY, where medically indicated, not being a service associated with a service to which item 35536 applies (Anaes.) Fee: \$283.65 Benefit: 75% = \$212.75	85% = \$241.15	
35536	VULVA, wide local excision of suspected malignancy or hemivulvectomy, 1 or both procedures (Anaes.) (Assist.) Fee: \$282.50 Benefit: 75% = \$211.90	85% = \$240.15	
35539	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 1 anatomical site (Anaes.) Fee: \$221.30 Benefit: 75% = \$166.00	85% = \$188.15	
35542	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for previously confirmed intraepithelial neoplastic changes of the cervix, vagina, vulva, urethra or anal canal, including any associated biopsies 2 or more anatomical sites (Anaes.) (Assist.) Fee: \$259.10 Benefit: 75% = \$194.35	85% = \$220.25	
35545	COLPOSCOPICALLY DIRECTED CO ² LASER THERAPY for condylomata, unsuccessfully treated by other methods (Anaes.) Fee: \$148.95 Benefit: 75% = \$111.75	85% = \$126.65	
35548	VULVECTOMY, radical, for malignancy (Anaes.) (Assist.) Fee: \$676.30 Benefit: 75% = \$507.25	85% = \$619.20	
35551	PELVIC LYMPH GLANDS, excision of (radical) (Anaes.) (Assist.) Fee: \$554.45 Benefit: 75% = \$415.85	85% = \$497.35	
35554	VAGINA, DILATATION OF, as an independent procedure including any associated consultation (Anaes.) Fee: \$35.25 Benefit: 75% = \$26.45	85% = \$30.00	
35557	VAGINA, removal of simple tumour (including Gartner duct cyst) (Anaes.) Fee: \$173.90 Benefit: 75% = \$130.45	85% = \$147.85	
35560	VAGINA, partial or complete removal of (Anaes.) (Assist.) Fee: \$554.45 Benefit: 75% = \$415.85	85% = \$497.35	
35561	VAGINECTOMY, radical, for proven invasive malignancy - 1 surgeon (Anaes.) (Assist.) Fee: \$1,118.55 Benefit: 75% = \$838.95	85% = \$1,061.45	
35562	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - abdominal surgeon (including aftercare) (Anaes.) (Assist.) Fee: \$918.35 Benefit: 75% = \$688.80	85% = \$861.25	
35564	VAGINECTOMY, radical, for proven invasive malignancy, conjoint surgery - perineal surgeon (Assist.) Fee: \$423.95 Benefit: 75% = \$318.00	85% = \$366.85	
35565	VAGINAL RECONSTRUCTION for congenital absence, gynatresia or urogenital sinus (Anaes.) (Assist.) Fee: \$554.45 Benefit: 75% = \$415.85	85% = \$497.35	

OPERATIONS		GYNAECOLOGICAL	
35613	CERVIX, RESIDUAL STUMP, removal of, by vaginal approach (Anaes.) (Assist.) Fee: \$328.25 Benefit: 75% = \$246.20 85% = \$279.05		
35614	EXAMINATION OF LOWER FEMALE GENITAL TRACT by a Hinselmanntype colposcope in a patient with a previous abnormal cervical smear or a history of maternal ingestion of oestrogen or where a patient, because of suspicious signs of cancer, has been referred by another medical practitioner (Anaes.) <i>(See para T8.33 of explanatory notes to this Category)</i> Fee: \$51.75 Benefit: 75% = \$38.85 85% = \$44.00		
35615	VULVA, biopsy of, when performed in conjunction with a service to which item 35614 applies Fee: \$43.50 Benefit: 75% = \$32.65 85% = \$37.00		
35616	ENDOMETRIUM, endoscopic examination of and ablation of, by microwave, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage (Anaes.) Fee: \$364.50 Benefit: 75% = \$273.40 85% = \$309.85		
35617 G 35618 S	CERVIX, cone biopsy, amputation or repair of, not being a service to which item 35584 applies (Anaes.) Fee: \$140.80 Benefit: 75% = \$105.60 85% = \$119.70 Fee: \$176.75 Benefit: 75% = \$132.60 85% = \$150.25		
35620	ENDOMETRIAL BIOPSY where malignancy is suspected in patients with abnormal uterine bleeding or post menopausal bleeding (Anaes.) Fee: \$43.20 Benefit: 75% = \$32.40 85% = \$36.75		
35622	ENDOMETRIUM, endoscopic ablation of, by laser or diathermy, for chronic refractory menorrhagia including any hysteroscopy performed on the same day, with or without uterine curettage, not being a service associated with a service to which item 30390 applies (Anaes.) Fee: \$488.50 Benefit: 75% = \$366.40 85% = \$431.40		
35623	HYSTEROSCOPIC RESECTION of myoma, or myoma and uterine septum resection (where both are performed), followed by endometrial ablation by laser or diathermy (Anaes.) Fee: \$664.20 Benefit: 75% = \$498.15 85% = \$607.10		
35626	HYSTEROSCOPY, including biopsy, performed by a specialist in the practice of his or her specialty where the patient is referred to him or her for the investigation of suspected intrauterine pathology (with or without local anaesthetic), not being a service associated with a service to which item 35627 or 35630 applies <i>(See para T8.34 of explanatory notes to this Category)</i> Fee: \$67.15 Benefit: 75% = \$50.40 85% = \$57.10		
35627	HYSTEROSCOPY with dilatation of the cervix performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35630 applies (Anaes.) Fee: \$86.90 Benefit: 75% = \$65.20 85% = \$73.90		
35630	HYSTEROSCOPY, with endometrial biopsy, performed in the operating theatre of a hospital or approved day-hospital facility - not being a service associated with a service to which item 35626 or 35627 applies (Anaes.) Fee: \$148.40 Benefit: 75% = \$111.30 85% = \$126.15		
35633	HYSTEROSCOPY with uterine adhesiolysis or polypectomy or tubal catheterisation (including for insertion of device for sterilisation) or removal of IUD which cannot be removed by other means, 1 or more of (Anaes.) Fee: \$176.75 Benefit: 75% = \$132.60 85% = \$150.25		
35634	HYSTEROSCOPIC RESECTION of uterine septum followed by endometrial ablation by laser or diathermy (Anaes.) Fee: \$555.95 Benefit: 75% = \$417.00 85% = \$498.85		
35635	HYSTEROSCOPY involving resection of the uterine septum (Anaes.) Fee: \$242.80 Benefit: 75% = \$182.10 85% = \$206.40		
35636	HYSTEROSCOPY, involving resection of myoma, or resection of myoma and uterine septum (where both are performed) (Anaes.) Fee: \$351.10 Benefit: 75% = \$263.35 85% = \$298.45		
35637	LAPAROSCOPY, involving puncture of cysts, diathermy of endometriosis, ventrosuspension, division of adhesions or similar procedure - 1 or more procedures with or without biopsy - not being a service associated with any other laparoscopic procedure or hysterectomy (Anaes.) (Assist.) Fee: \$329.70 Benefit: 75% = \$247.30 85% = \$280.25		

OPERATIONS		GYNAECOLOGICAL
35638	COMPLICATED OPERATIVE LAPAROSCOPY, including use of laser when required, for 1 or more of the following procedures; oophorectomy, ovarian cystectomy, myomectomy, salpingectomy or salpingostomy, ablation of moderate or severe endometriosis requiring more than 1 hours operating time, or division of utero-sacral ligaments for significant dysmenorrhoea - not being a service associated with any other intraperitoneal or retroperitoneal procedure except item 30393 (Anaes.) (Assist.) Fee: \$576.90 Benefit: 75% = \$432.70 85% = \$519.80	
35639 G 35640 S	UTERUS, CURETTAGE OF, with or without dilatation (including curettage for incomplete miscarriage) under general anaesthesia, or under epidural or spinal (intrathecal) nerve block where undertaken in a hospital or approved day hospital facility, including procedures to which item 35626 , 35627 or 35630 applies, where performed (Anaes.) <i>(See para T8.35 of explanatory notes to this Category)</i> Fee: \$109.40 Benefit: 75% = \$82.05 85% = \$93.00 Fee: \$148.40 Benefit: 75% = \$111.30 85% = \$126.15	
35641	ENDOMETRIOSIS LEVEL 4 OR 5, LAPAROSCOPIC RESECTION OF, involving any two of the following procedures, resection of the pelvic side wall including dissection of endometriosis or scar tissue from the ureter, resection of the Pouch of Douglas, resection of an ovarian endometrioma greater than 2 cms in diameter, dissection of bowel from uterus from the level of the endocervical junction or above: where the operating time exceeds 90 minutes (Anaes.) (Assist.) Fee: \$1,007.50 Benefit: 75% = \$755.65 85% = \$950.40	
35643	EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626 , 35627 or 35630 applies, where performed (Anaes.) Fee: \$176.75 Benefit: 75% = \$132.60 85% = \$150.25	
35644	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35639 , 35640 or 35647 applies (Anaes.) <i>(See para T8.36 of explanatory notes to this Category)</i> Fee: \$165.10 Benefit: 75% = \$123.85 85% = \$140.35	
35645	CERVIX, electrocoagulation diathermy with colposcopy, for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative therapy of additional areas of intraepithelial change in 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35648 applies (Anaes.) <i>(See para T8.36 of explanatory notes to this Category)</i> Fee: \$258.45 Benefit: 75% = \$193.85 85% = \$219.70	
35646	CERVIX, colposcopy with radical diathermy of, with or without cervical biopsy, for previously confirmed intraepithelial neoplastic changes of the cervix, where performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) <i>(See para T8.36 of explanatory notes to this Category)</i> Fee: \$165.10 Benefit: 75% = \$123.85 85% = \$140.35	
35647	CERVIX, large loop excision of transformation zone together with colposcopy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, not being a service associated with a service to which item 35644 applies (Anaes.) <i>(See para T8.36 of explanatory notes to this Category)</i> Fee: \$165.10 Benefit: 75% = \$123.85 85% = \$140.35	
35648	CERVIX, large loop excision diathermy for previously confirmed intraepithelial neoplastic changes of the cervix, including any local anaesthesia and biopsies, in conjunction with ablative treatment of additional areas of intraepithelial change of 1 or more sites of vagina, vulva, urethra or anus, not being a service associated with a service to which item 35645 applies (Anaes.) <i>(See para T8.36 of explanatory notes to this Category)</i> Fee: \$258.45 Benefit: 75% = \$193.85 85% = \$219.70	
35649	HYSTEROTOMY or UTERINE MYOMECTOMY, abdominal (Anaes.) (Assist.) Fee: \$434.60 Benefit: 75% = \$325.95 85% = \$377.50	
35653	HYSTERECTOMY, ABDOMINAL, SUBTOTAL or TOTAL, with or without removal of uterine adnexae (Anaes.) (Assist.) Fee: \$547.00 Benefit: 75% = \$410.25 85% = \$489.90	

OPERATIONS		GYNAECOLOGICAL	
	HYSTERECTOMY, VAGINAL, with or without uterine curettage, not being a service to which item 35673 applies NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note T8.33 before submitting a claim. (Anaes.) (Assist.) (See para T8.37 of explanatory notes to this Category)		
35657	Fee: \$547.00	Benefit: 75% = \$410.25	85% = \$489.90
	UTERUS (at least equivalent in size to a 10 week gravid uterus), debulking of, prior to vaginal removal at hysterectomy (Anaes.) (Assist.) (See para T8.38 of explanatory notes to this Category)		
35658	Fee: \$337.30	Benefit: 75% = \$253.00	85% = \$286.75
	HYSTERECTOMY, ABDOMINAL, requiring extensive retroperitoneal dissection, with or without exposure of 1 or both ureters, for the management of severe endometriosis, pelvic inflammatory disease or benign pelvic tumours, with or without conservation of the ovaries (Anaes.) (Assist.)		
35661	Fee: \$706.45	Benefit: 75% = \$529.85	85% = \$649.35
	RADICAL HYSTERECTOMY with radical excision of pelvic lymph glands (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)		
35664	Fee: \$1,177.35	Benefit: 75% = \$883.05	85% = \$1,120.25
	RADICAL HYSTERECTOMY without gland dissection (with or without excision of uterine adnexae) for proven malignancy including excision of any 1 or more of parametrium, paracolpos, upper vagina or contiguous pelvic peritoneum and involving ureterolysis where performed (Anaes.) (Assist.)		
35667	Fee: \$1,000.65	Benefit: 75% = \$750.50	85% = \$943.55
	HYSTERECTOMY, abdominal, with radical excision of pelvic lymph glands, with or without removal of uterine adnexae (Anaes.) (Assist.)		
35670	Fee: \$824.00	Benefit: 75% = \$618.00	85% = \$766.90
	HYSTERECTOMY, VAGINAL (with or without uterine curettage) with salpingectomy, oophorectomy or excision of ovarian cyst, 1 or more, 1 or both sides (Anaes.) (Assist.)		
35673	Fee: \$614.40	Benefit: 75% = \$460.80	85% = \$557.30
	ULTRASOUND GUIDED NEEDLING and injection of ectopic pregnancy		
35674	Fee: \$168.45	Benefit: 75% = \$126.35	85% = \$143.20
	ECTOPIC PREGNANCY, removal of (Anaes.) (Assist.)		
35676 G	Fee: \$344.60	Benefit: 75% = \$258.45	85% = \$292.95
35677 S	Fee: \$434.60	Benefit: 75% = \$325.95	85% = \$377.50
	ECTOPIC PREGNANCY, laparoscopic removal of (Anaes.) (Assist.)		
35678	Fee: \$523.95	Benefit: 75% = \$393.00	85% = \$466.85
	BICORNUATE UTERUS, plastic reconstruction for (Anaes.) (Assist.)		
35680	Fee: \$471.90	Benefit: 75% = \$353.95	85% = \$414.80
	UTERUS, SUSPENSION OR FIXATION OF, as an independent procedure (Anaes.) (Assist.)		
35683 G	Fee: \$284.80	Benefit: 75% = \$213.60	85% = \$242.10
35684 S	Fee: \$382.05	Benefit: 75% = \$286.55	85% = \$324.95
	STERILISATION BY TRANSECTION OR RESECTION OF FALLOPIAN TUBES, via abdominal or vaginal routes or via laparoscopy using diathermy or any other method. NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note T8.33 before submitting a claim. (Anaes.) (Assist.) (See para T8.37 of explanatory notes to this Category)		
35687 G	Fee: \$263.70	Benefit: 75% = \$197.80	85% = \$224.15
35688 S	Fee: \$322.10	Benefit: 75% = \$241.60	85% = \$273.80

OPERATIONS		GYNAECOLOGICAL	
	STERILISATION BY INTERRUPTION OF FALLOPIAN TUBES, when performed in conjunction with Caesarean section NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note T8.33 before submitting a claim. (Anaes.)		
35691	Fee: \$128.70	Benefit: 75% = \$96.55	85% = \$109.40
	TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)		
35694	Fee: \$517.00	Benefit: 75% = \$387.75	85% = \$459.90
	MICROSURGICAL TUBOPLASTY (salpingostomy, salpingolysis or tubal implantation into uterus), UNILATERAL or BILATERAL, 1 or more procedures (Anaes.) (Assist.)		
35697	Fee: \$767.15	Benefit: 75% = \$575.40	85% = \$710.05
	FALLOPIAN TUBES, unilateral microsurgical anastomosis of, using operating microscope, for other than reversal of previous sterilisation (Anaes.) (Assist.)		
35700	Fee: \$591.95	Benefit: 75% = \$444.00	85% = \$534.85
	HYDROTUBATION OF FALLOPIAN TUBES as a nonrepetitive procedure not being a service associated with a service to which another item in this Sub-group applies (Anaes.)		
35703	Fee: \$54.70	Benefit: 75% = \$41.05	85% = \$46.50
	RUBIN TEST FOR PATENCY OF FALLOPIAN TUBES (Anaes.)		
35706	Fee: \$54.70	Benefit: 75% = \$41.05	85% = \$46.50
	FALLOPIAN TUBES, hydrotubation of, as a repetitive postoperative procedure (Anaes.)		
35709	Fee: \$35.25	Benefit: 75% = \$26.45	85% = \$30.00
	FALLOPOSCOPY, unilateral or bilateral, including hysteroscopy and tubal catheterization (Anaes.) (Assist.)		
35710	Fee: \$375.65	Benefit: 75% = \$281.75	85% = \$319.35
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 1 such procedure, not being a service associated with hysterectomy (Anaes.) (Assist.)		
35712 G	Fee: \$293.65	Benefit: 75% = \$220.25	85% = \$249.65
35713 S	Fee: \$367.15	Benefit: 75% = \$275.40	85% = \$312.10
	LAPAROTOMY, involving OOPHORECTOMY, SALPINGECTOMY, SALPINGOOOPHORECTOMY, removal of OVARIAN, PARAOVARIAN, FIMBRIAL or BROAD LIGAMENT CYST - 2 or more such procedures, unilateral or bilateral, not being a service associated with hysterectomy (Anaes.) (Assist.)		
35716 G	Fee: \$352.15	Benefit: 75% = \$264.15	85% = \$299.35
35717 S	Fee: \$442.10	Benefit: 75% = \$331.60	85% = \$385.00
	RADICAL OR DEBULKING OPERATION for advanced gynaecological malignancy, with or without omentectomy (Anaes.) (Assist.) <i>(See para T8.43 of explanatory notes to this Category)</i>		
35720	Fee: \$546.90	Benefit: 75% = \$410.20	85% = \$489.80
	RETROPERITONEAL LYMPH NODE BIOPSIES from above the level of the aortic bifurcation, for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)		
35723	Fee: \$391.65	Benefit: 75% = \$293.75	85% = \$334.55
	INFRACOLIC OMENTECTOMY with multiple peritoneal biopsies for staging or restaging of gynaecological malignancy (Anaes.) (Assist.)		
35726	Fee: \$391.65	Benefit: 75% = \$293.75	85% = \$334.55
	OVARIAN TRANSPOSITION out of the pelvis, in conjunction with radical hysterectomy for invasive malignancy (Anaes.)		
35729	Fee: \$176.60	Benefit: 75% = \$132.45	85% = \$150.15
	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, including any associated laparoscopy (Anaes.) (Assist.)		
35750	Fee: \$636.15	Benefit: 75% = \$477.15	85% = \$579.05
	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst or treatment of moderate endometriosis, one or both sides, including any associated laparoscopy (Anaes.) (Assist.)		
35753	Fee: \$703.45	Benefit: 75% = \$527.60	85% = \$646.35

OPERATIONS		UROLOGICAL
35754	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY which requires dissection of endometriosis, or other pathology, from the ureter, one or both sides, including any associated laparoscopy, including when performed with one or more of the following procedures: salpingectomy, oophorectomy, excision of ovarian cyst, or treatment of endometriosis, not being a service to which item 35641 applies (Anaes.) (Assist.) Fee: \$885.20 Benefit: 75% = \$663.90 85% = \$828.10	
35756	LAPAROSCOPICALLY ASSISTED HYSTERECTOMY, when procedure is completed by open hysterectomy, including any associated laparoscopy (Anaes.) (Assist.) Fee: \$636.15 Benefit: 75% = \$477.15 85% = \$579.05	
35759	Procedure for the control of POST OPERATIVE HAEMORRHAGE following gynaecological surgery, under general anaesthesia, utilising a vaginal or abdominal and vaginal approach where no other procedure is performed (Anaes.) (Assist.) Fee: \$456.70 Benefit: 75% = \$342.55 85% = \$399.60	
SUBGROUP 5 - UROLOGICAL		
GENERAL		
36500	ADRENAL GLAND, excision of partial or total (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36502	PELVIC LYMPHADENECTOMY, open or laparoscopic, or both, unilateral or bilateral (Anaes.) (Assist.) Fee: \$554.45 Benefit: 75% = \$415.85 85% = \$497.35	
36503	RENAL TRANSPLANT (not being a service to which item 36506 or 36509 applies) (Anaes.) (Assist.) Fee: \$1,127.90 Benefit: 75% = \$845.95 85% = \$1,070.80	
36506	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together vascular anastomosis including aftercare (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36509	RENAL TRANSPLANT, performed by vascular surgeon and urologist operating together ureterovesical anastomosis including aftercare (Assist.) Fee: \$634.85 Benefit: 75% = \$476.15 85% = \$577.75	
36516	NEPHRECTOMY, complete (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36519	NEPHRECTOMY, complete, complicated by previous surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,046.85 Benefit: 75% = \$785.15 85% = \$989.75	
36522	NEPHRECTOMY, partial (Anaes.) (Assist.) Fee: \$898.30 Benefit: 75% = \$673.75 85% = \$841.20	
36525	NEPHRECTOMY, partial, complicated by previous surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,276.55 Benefit: 75% = \$957.45 85% = \$1,219.45	
36528	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10 cms in diameter (Anaes.) (Assist.) Fee: \$1,046.85 Benefit: 75% = \$785.15 85% = \$989.75	
36529	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10 cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney (Anaes.) (Assist.) Fee: \$1,291.90 Benefit: 75% = \$968.95 85% = \$1,234.80	
36531	NEPHROURETERECTOMY, complete, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$938.75 Benefit: 75% = \$704.10 85% = \$881.65	
36532	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$1,347.40 Benefit: 75% = \$1,010.55 85% = \$1,290.30	

OPERATIONS		UROLOGICAL
36533	NEPHRO-URETERECTOMY, for tumour, with or without en bloc dissection of lymph nodes, including associated bladder repair and any associated endoscopic procedures, complicated by previous open or laparoscopic surgery on the same kidney or ureter (Anaes.) (Assist.) Fee: \$1,592.45 Benefit: 75% = \$1,194.35 85% = \$1,535.35	
36537	KIDNEY OR PERINEPHRIC AREA, EXPLORATION OF, with or without drainage of, by open exposure, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
36540	NEPHROLITHOTOMY OR PYEOLITHOTOMY, or both, through the same skin incision, for 1 or 2 stones (Anaes.) (Assist.) Fee: \$898.30 Benefit: 75% = \$673.75 85% = \$841.20	
36543	NEPHROLITHOTOMY OR PYEOLITHOTOMY, or both, extended, for staghorn stone or 3 or more stones, including 1 or more of the following: nephrostomy, pyelostomy, pedicle control with or without freezing, calyorrhaphy or pyeloplasty (Anaes.) (Assist.) Fee: \$1,046.85 Benefit: 75% = \$785.15 85% = \$989.75	
36546	EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY (ESWL) to urinary tract and posttreatment care for 3 days, including pretreatment consultation, unilateral (Anaes.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
36549	URETEROLITHOTOMY (Anaes.) (Assist.) Fee: \$675.40 Benefit: 75% = \$506.55 85% = \$618.30	
36552	NEPHROSTOMY or pyelostomy, open, as an independent procedure (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
36558	RENAL CYST OR CYSTS, excision or unroofing of (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	
36561	RENAL BIOPSY (closed) (Anaes.) Fee: \$139.85 Benefit: 75% = \$104.90 85% = \$118.90	
36564	PYELOPLASTY, by open exposure (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36567	PYELOPLASTY in a kidney that is congenitally abnormal in addition to the presence of PUJ obstruction, or in a solitary kidney, by open exposure (Anaes.) (Assist.) Fee: \$824.00 Benefit: 75% = \$618.00 85% = \$766.90	
36570	PYELOPLASTY, complicated by previous surgery on the same kidney, by open exposure (Anaes.) (Assist.) Fee: \$1,046.85 Benefit: 75% = \$785.15 85% = \$989.75	
36573	DIVIDED URETER, repair of (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36576	KIDNEY, exposure and exploration of, including repair or nephrectomy, for trauma, not being a service associated with any other procedure performed on the kidney, renal pelvis or renal pedicle (Anaes.) (Assist.) Fee: \$938.75 Benefit: 75% = \$704.10 85% = \$881.65	
36579	URETERECTOMY, COMPLETE OR PARTIAL, with or without associated bladder repair, not being a service associated with a service to which item 37000 applies (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
36585	URETER, transplantation of, into skin (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
36588	URETER, reimplantation into bladder (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36591	URETER, reimplantation into bladder with psoas hitch or Boari flap or both (Anaes.) (Assist.) Fee: \$898.30 Benefit: 75% = \$673.75 85% = \$841.20	
36594	URETER, transplantation of, into intestine (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	

OPERATIONS		UROLOGICAL
36597	URETER, transplantation of, into another ureter (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
36600	URETER, transplantation of, into isolated intestinal segment, unilateral (Anaes.) (Assist.) Fee: \$898.30 Benefit: 75% = \$673.75 85% = \$841.20	
36603	URETERS, transplantation of, into isolated intestinal segment, bilateral (Anaes.) (Assist.) Fee: \$1,046.85 Benefit: 75% = \$785.15 85% = \$989.75	
36604	URETERIC STENT, passage of through percutaneous nephrostomy tube, using interventional imaging techniques (Anaes.) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
36606	INTESTINAL URINARY RESERVOIR, continent, formation of, including formation of nonreturn valves and implantation of ureters (1 or both) into reservoir (Anaes.) (Assist.) Fee: \$1,877.60 Benefit: 75% = \$1,408.20 85% = \$1,820.50	
36609	INTESTINAL URINARY CONDUIT OR URETEROSTOMY, revision of (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
36612	URETER, exploration of, with or without drainage of, as an independent procedure (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	
36615	URETEROLYSIS, with or without repositioning of the ureter, for obstruction of the ureter, evident either radiologically or by proximal ureteric dilatation at operation, secondary to retroperitoneal fibrosis, or similar condition (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
36618	REDUCTION URETEROPLASTY (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	
36621	CLOSURE OF CUTANEOUS URETEROSTOMY (Anaes.) (Assist.) Fee: \$376.60 Benefit: 75% = \$282.45 85% = \$320.15	
36624	NEPHROSTOMY, percutaneous, using interventional imaging techniques (Anaes.) (Assist.) Fee: \$452.50 Benefit: 75% = \$339.40 85% = \$395.40	
36627	NEPHROSCOPY, percutaneous, with or without any 1 or more of; stone extraction, biopsy or diathermy, not being a service to which item 36639, 36642, 36645 or 36648 applies (Anaes.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
36630	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36627 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) Fee: \$276.95 Benefit: 75% = \$207.75 85% = \$235.45	
36633	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, not being a service associated with a service to which item 36627 , 36639 , 36642 , 36645 or 36648 applies (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
36636	NEPHROSCOPY, percutaneous, with incision of any 1 or more of; renal pelvis, calyx or calyces or ureter and including antegrade insertion of ureteric stent, being a service associated with a service to which item 36627 , 36639 , 36642 , 36645 or 36648 applies (Anaes.) (Assist.) Fee: \$324.25 Benefit: 75% = \$243.20 85% = \$275.65	
36639	NEPHROSCOPY, percutaneous, with destruction and extraction of 1 or 2 stones using ultrasound or electrohydraulic shock waves or lasers (not being a service to which item 36645 or 36648 applies) (Anaes.) Fee: \$675.40 Benefit: 75% = \$506.55 85% = \$618.30	
36642	NEPHROSCOPY, BEING A SERVICE TO WHICH ITEM 36639 APPLIES, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION DUE TO BLEEDING (Anaes.) (Assist.) Fee: \$337.70 Benefit: 75% = \$253.30 85% = \$287.05	
36645	NEPHROSCOPY, percutaneous, with removal or destruction of a stone greater than 3 cm in any dimension, or for 3 or more stones (Anaes.) (Assist.) Fee: \$864.50 Benefit: 75% = \$648.40 85% = \$807.40	

OPERATIONS		UROLOGICAL
36648	NEPHROSCOPY, being a service to which item 36645 applies, WHERE, after a substantial portion of the procedure has been performed, IT IS NECESSARY TO DISCONTINUE THE OPERATION (Anaes.) (Assist.) Fee: \$770.00 Benefit: 75% = \$577.50 85% = \$712.90	
36649	NEPHROSTOMY DRAINAGE TUBE, exchange of - but not including imaging (Anaes.) (Assist.) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45	
36652	PYELOSCOPY, retrograde, of one collecting system, with or without any one or more of, cystoscopy, ureteric meatotomy, ureteric dilatation, not being a service associated with a service to which item 36803 , 36812 or 36824 applies (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	
36654	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus 1 or more of extraction of stone from the renal pelvis or calyces, or biopsy or diathermy of the renal pelvis or calyces, not being a service associated with a service to which item 36656 applies to a procedure performed in the same collecting system (Assist.) Fee: \$675.40 Benefit: 75% = \$506.55 85% = \$618.30	
36656	PYELOSCOPY, retrograde, of one collecting system, being a service to which item 36652 applies, plus extraction of 2 or more stones in the renal pelvis or calyces or destruction of stone with ultrasound, electrohydraulic or kinetic lithotripsy, or laser in the renal pelvis or calyces, with or without extraction of fragments, not being a service associated with a service to which item 36654 applies to a procedure performed in the same collecting system (Anaes.) (Assist.) Fee: \$864.50 Benefit: 75% = \$648.40 85% = \$807.40	
OPERATIONS ON THE BLADDER (CLOSED)		
36800	BLADDER, catheterisation of, where no other procedure is performed (Anaes.) Fee: \$22.40 Benefit: 75% = \$16.80 85% = \$19.05	
36803	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, not being a service associated with a service to which item 36652 , 36654 , 36656 , 36806 , 36809 , 36812 , 36824 , 36848 or 36857 applies (Anaes.) (Assist.) Fee: \$378.10 Benefit: 75% = \$283.60 85% = \$321.40	
36806	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, plus one or more of extraction of stone from the ureter, or biopsy or diathermy of the ureter, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36809 , 36824 , 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	
36809	URETEROSCOPY, of one ureter, with or without any one or more of, cystoscopy, ureteric meatotomy or ureteric dilatation, PLUS destruction of stone in the ureter with ultrasound, electrohydraulic or kinetic lithotripsy, or laser, with or without extraction of fragments, not being a service associated with a service to which item 36803 or 36812 applies, or a service associated with a service to which item 36806 , 36824 , 36848 or 36857 applies to a procedure performed on the same ureter (Anaes.) (Assist.) Fee: \$675.40 Benefit: 75% = \$506.55 85% = \$618.30	
36811	CYSTOSCOPY with insertion of urethral prosthesis (Anaes.) Fee: \$262.20 Benefit: 75% = \$196.65 85% = \$222.90	
36812	CYSTOSCOPY with urethroscopy with or without urethral dilatation, not being a service associated with any other urological endoscopic procedure on the lower urinary tract except a service to which item 37327 applies (Anaes.) Fee: \$135.10 Benefit: 75% = \$101.35 85% = \$114.85	
36815	CYSTOSCOPY, with or without urethroscopy, for the treatment of penile warts or urethral warts, not being a service associated with a service to which item 30189 applies (Anaes.) <i>(See para T8.12 of explanatory notes to this Category)</i> Fee: \$192.90 Benefit: 75% = \$144.70 85% = \$164.00	
36818	CYSTOSCOPY with ureteric catheterisation including fluoroscopic imaging of the upper urinary tract, unilateral or bilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
36821	CYSTOSCOPY with 1 or more of, ureteric dilatation, insertion of ureteric stent, or brush biopsy of ureter or renal pelvis, unilateral, not being a service associated with a service to which item 36824 or 36830 applies (Anaes.) (Assist.) Fee: \$262.05 Benefit: 75% = \$196.55 85% = \$222.75	
36824	CYSTOSCOPY, with ureteric catheterisation, unilateral or bilateral, not being a service associated with a service to which item 36818 or 36821 applies (Anaes.) Fee: \$172.85 Benefit: 75% = \$129.65 85% = \$146.95	

OPERATIONS		UROLOGICAL	
36825	CYSTOSCOPY, with endoscopic incision of pelviureteric junction or ureteric stricture, including removal or replacement of ureteric stent, not being a service associated with a service to which item 36818 , 36821 , 36824 , 36830 or 36833 applies (Anaes.) (Assist.) Fee: \$471.30	Benefit: 75% = \$353.50	85% = \$414.20
36827	CYSTOSCOPY, with controlled hydrodilatation of the bladder (Anaes.) Fee: \$186.40	Benefit: 75% = \$139.80	85% = \$158.45
36830	CYSTOSCOPY, with ureteric meatotomy (Anaes.) Fee: \$164.85	Benefit: 75% = \$123.65	85% = \$140.15
36833	CYSTOSCOPY, with removal of ureteric stent or other foreign body (Anaes.) (Assist.) Fee: \$224.20	Benefit: 75% = \$168.15	85% = \$190.60
36836	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812 , 36830 , 36839 , 36845 , 36848 , 36854 , 37203 , 37206 or 37215 applies (Anaes.) Fee: \$186.40	Benefit: 75% = \$139.80	85% = \$158.45
36839	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder or prostate, not being a service associated with a service to which item 36845 applies (Anaes.) Fee: \$262.05	Benefit: 75% = \$196.55	85% = \$222.75
36842	CYSTOSCOPY, with lavage of blood clots from bladder including any associated diathermy of prostate or bladder and not being a service associated with a service to which item 36812 , 36827 to 36863 , 37203 or 37206 apply (Anaes.) (Assist.) Fee: \$263.70	Benefit: 75% = \$197.80	85% = \$224.15
36845	CYSTOSCOPY, with diathermy, resection or visual laser destruction of multiple tumours in more than 2 quadrants of the bladder or solitary tumour greater than 2cm in diameter (Anaes.) Fee: \$560.60	Benefit: 75% = \$420.45	85% = \$503.50
36848	CYSTOSCOPY, with resection of ureterocele (Anaes.) Fee: \$186.40	Benefit: 75% = \$139.80	85% = \$158.45
36851	CYSTOSCOPY, with injection into bladder wall (Anaes.) Fee: \$186.40	Benefit: 75% = \$139.80	85% = \$158.45
36854	CYSTOSCOPY, with endoscopic incision or resection of external sphincter, bladder neck or both (Anaes.) Fee: \$378.10	Benefit: 75% = \$283.60	85% = \$321.40
36857	ENDOSCOPIC MANIPULATION OR EXTRACTION of ureteric calculus (Anaes.) Fee: \$297.10	Benefit: 75% = \$222.85	85% = \$252.55
36860	ENDOSCOPIC EXAMINATION of intestinal conduit or reservoir (Anaes.) Fee: \$135.10	Benefit: 75% = \$101.35	85% = \$114.85
36863	LITHOLAPAXY, with or without cystoscopy (Anaes.) (Assist.) Fee: \$378.10	Benefit: 75% = \$283.60	85% = \$321.40
OPERATIONS ON THE BLADDER (OPEN)			
37000	BLADDER, partial excision of (Anaes.) (Assist.) Fee: \$601.15	Benefit: 75% = \$450.90	85% = \$544.05
37004	BLADDER, repair of rupture (Anaes.) (Assist.) Fee: \$526.85	Benefit: 75% = \$395.15	85% = \$469.75
37008	CYSTOSTOMY OR CYSTOTOMY, suprapubic, not being a service to which item 37011 applies and not being a service associated with other open bladder procedure (Anaes.) Fee: \$337.70	Benefit: 75% = \$253.30	85% = \$287.05
37011	SUPRAPUBIC STAB CYSTOTOMY, not being a service associated with a service to which items 37200 to 37221 apply (Anaes.) Fee: \$75.60	Benefit: 75% = \$56.70	85% = \$64.30

OPERATIONS		UROLOGICAL
37014	BLADDER, total excision of (Anaes.) (Assist.) Fee: \$864.50 Benefit: 75% = \$648.40 85% = \$807.40	
37020	BLADDER DIVERTICULUM, excision or obliteration of (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
37023	VESICAL FISTULA, cutaneous, operation for (Anaes.) Fee: \$337.70 Benefit: 75% = \$253.30 85% = \$287.05	
37026	CUTANEOUS VESICOSTOMY, establishment of (Anaes.) (Assist.) Fee: \$337.70 Benefit: 75% = \$253.30 85% = \$287.05	
37029	VESICOVAGINAL FISTULA, closure of, by abdominal approach (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37038	VESICOINTESTINAL FISTULA, closure of, excluding bowel resection (Anaes.) (Assist.) Fee: \$560.95 Benefit: 75% = \$420.75 85% = \$503.85	
37041	BLADDER ASPIRATION by needle Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15	
37042	BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, not being a service to which item 35599 applies (Anaes.) (Assist.) Fee: \$738.90 Benefit: 75% = \$554.20 85% = \$681.80	
37043	BLADDER STRESS INCONTINENCE, Stamey or similar type needle colposuspension, not being a service to which item 35599 applies (Anaes.) (Assist.) Fee: \$546.90 Benefit: 75% = \$410.20 85% = \$489.80	
37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, e.g. Burch colposuspension, not being a service to which item 35599 applies (Anaes.) (Assist.) Fee: \$560.95 Benefit: 75% = \$420.75 85% = \$503.85	
37045	MITROFANOFF CONTINENT VALVE, formation of (Anaes.) (Assist.) Fee: \$1,158.40 Benefit: 75% = \$868.80 85% = \$1,101.30	
37047	BLADDER ENLARGEMENT using intestine (Anaes.) (Assist.) Fee: \$1,350.80 Benefit: 75% = \$1,013.10 85% = \$1,293.70	
37050	BLADDER EXSTROPHY CLOSURE, not involving sphincter reconstruction (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
37053	BLADDER TRANSECTION AND RE-ANASTOMOSIS TO TRIGONE (Anaes.) (Assist.) Fee: \$694.65 Benefit: 75% = \$521.00 85% = \$637.55	
	OPERATIONS ON THE PROSTATE	
37200	PROSTATECTOMY, open (Anaes.) (Assist.) Fee: \$824.00 Benefit: 75% = \$618.00 85% = \$766.90	
37201	PROSTATE, transurethral radio-frequency needle ablation of the, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is, prostatectomy using diathermy or cold punch) and including services to which item 36854 , 37203 , 37206 , 37207 , 37208 , 37303 , 37321 or 37324 applies (Ministerial Determination) (Anaes.) <i>(See para T8.40 of explanatory notes to this Category)</i> Fee: \$672.10 Benefit: 75% = \$504.10 85% = \$615.00	
37202	PROSTATE, transurethral radio-frequency needle ablation of the, with or without cystoscopy and with or without urethroscopy, in patients with moderate to severe lower urinary tract symptoms who are not medically fit for transurethral resection of the prostate (that is prostatectomy using diathermy or cold punch) and including services to which item 36854 , 37303 , 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37203 , 37207 , 37201 which had to be discontinued for medical reasons (Ministerial Determination) (Anaes.) <i>(See para T8.40 of explanatory notes to this Category)</i> Fee: \$337.30 Benefit: 75% = \$253.00 85% = \$286.75	

OPERATIONS		UROLOGICAL
37203	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854 , 37201 , 37202 , 37207 , 37208 , 37303 , 37321 or 37324 applies (Anaes.) Fee: \$844.90 Benefit: 75% = \$633.70 85% = \$787.80	
37206	PROSTATECTOMY (endoscopic, using diathermy or cold punch), with or without cystoscopy and with or without urethroscopy, and including services to which item 36854 , 37303 , 37321 or 37324 applies, continuation of, within 10 days of the procedure described by item 37201 , 37203 , 37208 or which had to be discontinued for medical reasons (Anaes.) Fee: \$452.50 Benefit: 75% = \$339.40 85% = \$395.40	
37207	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854 , 37201 , 37202 , 37203 , 37206 , 37321 or 37324 applies (Anaes.) Fee: \$702.55 Benefit: 75% = \$526.95 85% = \$645.45	
37208	PROSTATE, endoscopic non-contact (side firing) visual laser ablation, with or without cystoscopy and with or without urethroscopy, and including services to which items 36854 , 37203 , 37321 or 37324 applies, continuation of, within 10 days of the procedure described by items 37201 , 37203 , 37207 or which had to be discontinued for medical reasons (Anaes.) Fee: \$337.30 Benefit: 75% = \$253.00 85% = \$286.75	
37209	PROSTATE, and/or SEMINAL VESICLE/AMPULLA OF VAS, unilateral or bilateral, total excision of, not being a service associated with a service to which item number 37210 or 37211 applies (Anaes.) (Assist.) Fee: \$1,046.85 Benefit: 75% = \$785.15 85% = \$989.75	
37210	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, not being a service associated with a service to which item 35551 , 36502 or 37375 applies (Anaes.) (Assist.) Fee: \$1,291.90 Benefit: 75% = \$968.95 85% = \$1,234.80	
37211	PROSTATECTOMY, radical, involving total excision of the prostate, sparing of nerves around the bladder and bladder neck reconstruction, <i>with pelvic lymphadenectomy</i> , not being a service associated with a service to which item 35551 , 36502 or 37375 applies (Anaes.) (Assist.) Fee: \$1,569.05 Benefit: 75% = \$1,176.80 85% = \$1,511.95	
37212	PROSTATE, open perineal biopsy or open drainage of abscess (Anaes.) (Assist.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
37215	PROSTATE, biopsy of, endoscopic, with or without cystoscopy (Anaes.) (Assist.) Fee: \$337.70 Benefit: 75% = \$253.30 85% = \$287.05	
37218	PROSTATE, needle biopsy of, or injection into (Anaes.) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35	
37219	PROSTATE, transrectal needle biopsy of, using transrectal prostatic ultrasound techniques and obtaining 1 or more prostatic specimens, being a service associated with a service to which item 55600 or 55603 applies (Anaes.) (Assist.) Fee: \$227.70 Benefit: 75% = \$170.80 85% = \$193.55	
37220	PROSTATE, radioactive seed implantation of, urological component, using transrectal ultrasound guidance, for localised prostatic malignancy at clinical stages T1, T2A or T2B, with a Gleason score of less than or equal to 6 and a prostate specific antigen (PSA) of less than or equal to 10ng/ml at the time of diagnosis. The procedure must be performed by a urologist at an approved site in association with a radiation oncologist, and be associated with a service to which item 55603 applies. <i>(See para T8.42 of explanatory notes to this Category)</i> Fee: \$846.65 Benefit: 75% = \$635.00 85% = \$789.55	
37221	PROSTATIC ABSCESS, endoscopic drainage of (Anaes.) (Assist.) Fee: \$378.10 Benefit: 75% = \$283.60 85% = \$321.40	
37223	PROSTATIC COIL, insertion of, under ultrasound control (Anaes.) Fee: \$167.20 Benefit: 75% = \$125.40 85% = \$142.15	
OPERATIONS ON URETHRA, PENIS OR SCROTUM		
37300	URETHRAL SOUNDS, passage of, as an independent procedure (Anaes.) Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15	
37303	URETHRAL STRICTURE, dilatation of (Anaes.) Fee: \$60.05 Benefit: 75% = \$45.05 85% = \$51.05	
37306	URETHRA, repair of rupture of distal section (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	

OPERATIONS		UROLOGICAL
37309	URETHRA, repair of rupture of prostatic or membranous segment (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37315	URETHROSCOPY, as an independent procedure (Anaes.) Fee: \$112.15 Benefit: 75% = \$84.15 85% = \$95.35	
37318	URETHROSCOPY with any 1 or more of - biopsy, diathermy, visual laser destruction of stone or removal of foreign body or stone (Anaes.) (Assist.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
37321	URETHRAL MEATOTOMY, EXTERNAL (Anaes.) Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30	
37324	URETHROTOMY OR URETHROSTOMY, internal or external (Anaes.) Fee: \$186.40 Benefit: 75% = \$139.80 85% = \$158.45	
37327	URETHROTOMY, optical, for urethral stricture (Anaes.) (Assist.) Fee: \$262.05 Benefit: 75% = \$196.55 85% = \$222.75	
37330	URETHRECTOMY, partial or complete, for removal of tumour (Anaes.) (Assist.) Fee: \$526.85 Benefit: 75% = \$395.15 85% = \$469.75	
37333	URETHROVAGINAL FISTULA, closure of (Anaes.) (Assist.) Fee: \$452.50 Benefit: 75% = \$339.40 85% = \$395.40	
37336	URETHRORECTAL FISTULA, closure of (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
37339	PERIURETHRAL OR TRANSURETHRAL INJECTION of materials for the treatment of urinary incontinence, including cystoscopy and urethroscopy (Anaes.) Fee: \$194.50 Benefit: 75% = \$145.90 85% = \$165.35	
37340	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, vaginal approach, not being a service associated with a service to which item number 37341 applies (Anaes.) (Assist.) Fee: \$344.60 Benefit: 75% = \$258.45 85% = \$292.95	
37341	URETHRAL SLING, division or removal of, for urethral obstruction or erosion, following previous surgery for urinary incontinence, suprapubic or combined suprapubic/vaginal approach, not being a service associated with a service to which item number 37340 applies (Anaes.) (Assist.) Fee: \$738.90 Benefit: 75% = \$554.20 85% = \$681.80	
37342	URETHROPLASTY single stage operation (Anaes.) (Assist.) Fee: \$675.40 Benefit: 75% = \$506.55 85% = \$618.30	
37343	URETHROPLASTY, single stage operation, transpubic approach via separate incisions above and below the symphysis pubis, excluding laparotomy, symphysectomy and suprapubic cystotomy, with or without re-routing of the urethra around the crura (Anaes.) (Assist.) Fee: \$1,127.90 Benefit: 75% = \$845.95 85% = \$1,070.80	
37345	URETHROPLASTY 2 stage operation first stage (Anaes.) (Assist.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
37348	URETHROPLASTY 2 stage operation second stage (Anaes.) (Assist.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
37351	URETHROPLASTY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
37354	HYPOSPADIAS, meatotomy and hemircumcision (Anaes.) (Assist.) Fee: \$262.05 Benefit: 75% = \$196.55 85% = \$222.75	
37369	URETHRA, excision of prolapse of (Anaes.) Fee: \$151.25 Benefit: 75% = \$113.45 85% = \$128.60	
37372	URETHRAL DIVERTICULUM, excision of (Anaes.) (Assist.) Fee: \$378.10 Benefit: 75% = \$283.60 85% = \$321.40	

OPERATIONS		UROLOGICAL
37375	URETHRAL SPHINCTER, reconstruction by bladder tubularisation technique or similar procedure (Anaes.) (Assist.) Fee: \$938.75 Benefit: 75% = \$704.10 85% = \$881.65	
37381	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, perineal approach (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
37384	ARTIFICIAL URINARY SPHINCTER, insertion of cuff, abdominal approach (Anaes.) (Assist.) Fee: \$938.75 Benefit: 75% = \$704.10 85% = \$881.65	
37387	ARTIFICIAL URINARY SPHINCTER, insertion of pressure regulating balloon and pump (Anaes.) (Assist.) Fee: \$262.05 Benefit: 75% = \$196.55 85% = \$222.75	
37390	ARTIFICIAL URINARY SPHINCTER, revision or removal of, with or without replacement (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37393	PRIAPISM, decompression by glanular stab cavernospongiosum shunt or penile aspiration with or without lavage (Anaes.) Fee: \$186.40 Benefit: 75% = \$139.80 85% = \$158.45	
37396	PRIAPISM, shunt operation for, not being a service to which item 37393 applies (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
37402	PENIS, partial amputation of (Anaes.) (Assist.) Fee: \$378.10 Benefit: 75% = \$283.60 85% = \$321.40	
37405	PENIS, complete or radical amputation of (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37408	PENIS, repair of laceration of cavernous tissue, or fracture involving cavernous tissue (Anaes.) (Assist.) Fee: \$378.10 Benefit: 75% = \$283.60 85% = \$321.40	
37411	PENIS, repair of avulsion (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37415	PENIS, injection of, for the investigation and treatment of impotence - 2 services only in a period of 36 consecutive months Fee: \$37.80 Benefit: 75% = \$28.35 85% = \$32.15	
37417	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting (Anaes.) (Assist.) Fee: \$452.50 Benefit: 75% = \$339.40 85% = \$395.40	
37418	PENIS, correction of chordee, with or without excision of fibrous plaque or plaques and with or without grafting, involving mobilization of the urethra (Anaes.) (Assist.) Fee: \$601.15 Benefit: 75% = \$450.90 85% = \$544.05	
37420	PENIS, surgery to inhibit rapid penile drainage causing impotence, by ligation of veins deep to Buck's fascia including 1 or more deep cavernosal veins with or without pharmacological erection test (Anaes.) (Assist.) Fee: \$297.10 Benefit: 75% = \$222.85 85% = \$252.55	
37423	PENIS, lengthening by translocation of corpora (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37426	PENIS, artificial erection device, insertion of, into 1 or both corpora (Anaes.) (Assist.) Fee: \$790.15 Benefit: 75% = \$592.65 85% = \$733.05	
37429	PENIS, artificial erection device, insertion of pump and pressure regulating reservoir (Anaes.) (Assist.) Fee: \$262.05 Benefit: 75% = \$196.55 85% = \$222.75	
37432	PENIS, artificial erection device, complete or partial revision or removal of components, with or without replacement (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37435	PENIS, frenuloplasty as an independent procedure (Anaes.) Fee: \$75.60 Benefit: 75% = \$56.70 85% = \$64.30	
37438	SCROTUM, partial excision of (Anaes.) (Assist.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	

OPERATIONS		UROLOGICAL
37444	URETEROLITHOTOMY COMPLICATED BY PREVIOUS SURGERY at the same site of the same ureter (Anaes.) (Assist.) Fee: \$810.50 Benefit: 75% = \$607.90 85% = \$753.40	
OPERATIONS ON TESTES, VASA OR SEMINAL VESICLES		
37601	SPERMATOCELE OR EPIDIDYMAL CYST, excision of, 1 or more of, on 1 side (Anaes.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
37604	EXPLORATION OF SCROTAL CONTENTS, with or without fixation and with or without biopsy, unilateral, not being a service associated with sperm harvesting for IVF (Anaes.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
37607	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies (Anaes.) (Assist.) Fee: \$749.65 Benefit: 75% = \$562.25 85% = \$692.55	
37610	RETROPERITONEAL LYMPH NODE DISSECTION, unilateral, not being a service associated with a service to which item 36528 applies, following previous similar retroperitoneal dissection, retroperitoneal irradiation or chemotherapy (Anaes.) (Assist.) Fee: \$1,127.90 Benefit: 75% = \$845.95 85% = \$1,070.80	
37613	EPIDIDYMECTOMY (Anaes.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
37616	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, using operating microscope, for other than reversal of previous elective sterilisation, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
37619	VASOVASOSTOMY or VASOEPIDIDYMOSTOMY, unilateral, for other than reversal of previous elective sterilisation, not being a service associated with sperm harvesting for IVF (Anaes.) (Assist.) Fee: \$224.20 Benefit: 75% = \$168.15 85% = \$190.60	
	VASOTOMY OR VASECTOMY, unilateral or bilateral NOTE: Strict legal requirements apply in relation to sterilisation procedures on minors. Medicare benefits are not payable for services not rendered in accordance with relevant Commonwealth and State and Territory law. Observe note T8.33 before submitting a claim. (Anaes.) (See para T8.37 of explanatory notes to this Category)	
37622 G	Fee: \$156.70 Benefit: 75% = \$117.55 85% = \$133.20	
37623 S	Fee: \$186.40 Benefit: 75% = \$139.80 85% = \$158.45	
PAEDIATRIC GENITOURINARY SURGERY		
37800	PATENT URACHUS, excision of (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50	
37803	UNDESCENDED TESTIS, orchidopexy for, not being a service to which item 37806 applies (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50	
37806	UNDESCENDED TESTIS in inguinal canal close to deep inguinal ring or within abdominal cavity, orchidopexy for (Anaes.) (Assist.) Fee: \$488.30 Benefit: 75% = \$366.25 85% = \$431.20	
37809	UNDESCENDED TESTIS, revision orchidopexy for (Anaes.) (Assist.) Fee: \$488.30 Benefit: 75% = \$366.25 85% = \$431.20	
37812	IMPALPABLE TESTIS, exploration of groin for, not being a service associated with a service to which items 37803 to 37809 applies (Anaes.) (Assist.) Fee: \$450.85 Benefit: 75% = \$338.15 85% = \$393.75	
37815	HYPOSPADIAS, examination under anaesthesia with erection test (Anaes.) Fee: \$75.15 Benefit: 75% = \$56.40 85% = \$63.90	
37818	HYPOSPADIAS, glanuloplasty incorporating meatal advancement (Anaes.) (Assist.) Fee: \$398.45 Benefit: 75% = \$298.85 85% = \$341.35	

OPERATIONS		CARDIO-THORACIC
37821	HYPOSPADIAS, distal, 1 stage repair (Anaes.) (Assist.) Fee: \$675.40 Benefit: 75% = \$506.55 85% = \$618.30	
37824	HYPOSPADIAS, proximal, 1 stage repair (Anaes.) (Assist.) Fee: \$939.15 Benefit: 75% = \$704.40 85% = \$882.05	
37827	HYPOSPADIAS, staged repair, first stage (Anaes.) (Assist.) Fee: \$432.65 Benefit: 75% = \$324.50 85% = \$375.55	
37830	HYPOSPADIAS, staged repair, second stage (Anaes.) (Assist.) Fee: \$560.60 Benefit: 75% = \$420.45 85% = \$503.50	
37833	HYPOSPADIAS, repair of post operative urethral fistula (Anaes.) (Assist.) Fee: \$267.55 Benefit: 75% = \$200.70 85% = \$227.45	
37836	EPISPADIAS, staged repair, first stage (Anaes.) (Assist.) Fee: \$563.50 Benefit: 75% = \$422.65 85% = \$506.40	
37839	EPISPADIAS, staged repair, second stage (Anaes.) (Assist.) Fee: \$638.60 Benefit: 75% = \$478.95 85% = \$581.50	
37842	EXSTROPHY OF BLADDER OR EPISPADIAS, secondary repair with bladder neck tightening, with or without ureteric reimplantation (Anaes.) (Assist.) Fee: \$1,239.75 Benefit: 75% = \$929.85 85% = \$1,182.65	
37845	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty, with or without endoscopy (Anaes.) (Assist.) Fee: \$563.50 Benefit: 75% = \$422.65 85% = \$506.40	
37848	AMBIGUOUS GENITALIA WITH UROGENITAL SINUS, reduction clitoroplasty with endoscopy and vaginoplasty (Anaes.) (Assist.) Fee: \$1,014.25 Benefit: 75% = \$760.70 85% = \$957.15	
37851	CONGENITAL ADRENAL HYPERPLASIA, mixed gonadal dysgenesis or similar condition, vaginoplasty for, with or without endoscopy (Anaes.) (Assist.) Fee: \$751.40 Benefit: 75% = \$563.55 85% = \$694.30	
37854	URETHRAL VALVE, destruction of, including cystoscopy and urethroscopy (Anaes.) (Assist.) Fee: \$297.10 Benefit: 75% = \$222.85 85% = \$252.55	
SUBGROUP 6 - CARDIO-THORACIC		
MISCELLANEOUS CARDIAC PROCEDURES		
38200	RIGHT HEART CATHERISATION, including fluoroscopy, oximetry, dye dilution curves, cardiac output measurement by any method, shunt detection and exercise stress test (Anaes.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00	
38203	LEFT HEART CATHETERISATION by percutaneous arterial puncture, arteriotomy or percutaneous left ventricular puncture including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes.) Fee: \$430.95 Benefit: 75% = \$323.25 85% = \$373.85	
38206	RIGHT HEART CATHETERISATION WITH LEFT HEART CATHETERISATION via the right heart or by any other procedure including fluoroscopy, oximetry, dye dilution curves, cardiac output measurements by any method, shunt detection and exercise stress test (Anaes.) Fee: \$521.00 Benefit: 75% = \$390.75 85% = \$463.90	
38209	CARDIAC ELECTROPHYSIOLOGICAL STUDY up to and including 3 catheter investigation of any 1 or more of syncope, atrioventricular conduction, sinus node function or simple ventricular tachycardia studies, not being a service associated with a service to which item 38212 or 38213 applies (Anaes.) <i>(See para T8.44 of explanatory notes to this Category)</i> Fee: \$668.95 Benefit: 75% = \$501.75 85% = \$611.85	

OPERATIONS		CARDIO-THORACIC
38212	<p>CARDIAC ELECTROPHYSIOLOGICAL STUDY 4 or more catheter supraventricular tachycardia investigation; or complex tachycardia inductions, or multiple catheter mapping, or acute intravenous antiarrhythmic drug testing with pre and post drug inductions; or catheter ablation to intentionally induce complete AV block; or intraoperative mapping; or electrophysiological services during defibrillator implantation not being a service associated with a service to which item 38209 or 38213 applies (Anaes.) (See para T8.44 of explanatory notes to this Category)</p> <p>Fee: \$1,112.75 Benefit: 75% = \$834.60 85% = \$1,055.65</p>	
38213	<p>CARDIAC ELECTROPHYSIOLOGICAL STUDY, for follow-up testing of implanted defibrillator - not being a service associated with a service to which item 38209 or 38212 applies (Anaes.)</p> <p>Fee: \$331.30 Benefit: 75% = \$248.50 85% = \$281.65</p>	
38215	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries, not being a service associated with a service to which item 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$359.65 Benefit: 75% = \$269.75 85% = \$305.75</p>	
38218	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography, not being a service associated with a service to which item 38215, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$539.45 Benefit: 75% = \$404.60 85% = \$482.35</p>	
38220	<p>SELECTIVE CORONARY GRAFT ANGIOGRAPHY placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$179.85 Benefit: 75% = \$134.90 85% = \$152.90</p>	
38222	<p>SELECTIVE CORONARY GRAFT ANGIOGRAPHY, placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$359.65 Benefit: 75% = \$269.75 85% = \$305.75</p>	
38225	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$539.50 Benefit: 75% = \$404.65 85% = \$482.40</p>	
38228	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$719.35 Benefit: 75% = \$539.55 85% = \$662.25</p>	
38231	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material into the native coronary arteries and placement of catheter(s) and injection of opaque material into the free coronary graft(s) attached to the aorta (irrespective of the number of grafts), and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38234, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$899.20 Benefit: 75% = \$674.40 85% = \$842.10</p>	
38234	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38237, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$719.30 Benefit: 75% = \$539.50 85% = \$662.20</p>	

OPERATIONS		CARDIO-THORACIC	
38237	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38240 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$899.15 Benefit: 75% = \$674.40 85% = \$842.05</p>		
38240	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography and placement of catheter(s) and injection of opaque material into free coronary graft(s) attached to the aorta (irrespective of the number of grafts) and placement of catheter(s) and injection of opaque material into direct internal mammary artery graft(s) to one or more coronary arteries (irrespective of the number of grafts), not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237 or 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$1,078.95 Benefit: 75% = \$809.25 85% = \$1,021.85</p>		
38243	<p>PLACEMENT OF CATHETER(S) and injection of opaque material into any coronary vessel(s) or graft(s) prior to any coronary interventional procedure, not being a service associated with a service to which item 38246 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$359.65 Benefit: 75% = \$269.75 85% = \$305.75</p>		
38246	<p>SELECTIVE CORONARY ANGIOGRAPHY, placement of catheters and injection of opaque material with right or left heart catheterisation or both, or aortography followed by placement of catheters prior to any coronary interventional procedure, not being a service associated with a service to which item 38215, 38218, 38220, 38222, 38225, 38228, 38231, 38234, 38237, 38240 or 38243 applies (Anaes.) (See para T8.39 of explanatory notes to this Category)</p> <p>Fee: \$899.15 Benefit: 75% = \$674.40 85% = \$842.05</p>		
38256	<p>TEMPORARY TRANSVENOUS PACEMAKING ELECTRODE, insertion of (Anaes.)</p> <p>Fee: \$216.65 Benefit: 75% = \$162.50 85% = \$184.20</p>		
38270	<p>BALLOON VALVULOPLASTY OR SEPTOSTOMY, including cardiac catheterisations before and after balloon dilatation (Anaes.) (Assist.)</p> <p>Fee: \$739.65 Benefit: 75% = \$554.75 85% = \$682.55</p>		
38275	<p>MYOCARDIAL BIOPSY, by cardiac catheterisation (Anaes.)</p> <p>Fee: \$241.80 Benefit: 75% = \$181.35 85% = \$205.55</p>		
38278	<p>SINGLE CHAMBER PERMANENT TRANSVENOUS ELECTRODE, insertion, removal or replacement of (Anaes.)</p> <p>Fee: \$517.85 Benefit: 75% = \$388.40 85% = \$460.75</p>		
38281	<p>PERMANENT CARDIAC PACEMAKER, insertion, removal or replacement of (Anaes.) (See para T8.44 of explanatory notes to this Category)</p> <p>Fee: \$207.10 Benefit: 75% = \$155.35 85% = \$176.05</p>		
38284	<p>DUAL CHAMBER PERMANENT TRANSVENOUS ELECTRODES, insertion, removal or replacement of (Anaes.) (See para T8.44 of explanatory notes to this Category)</p> <p>Fee: \$678.95 Benefit: 75% = \$509.25 85% = \$621.85</p>		
ARRHYTHMIA ABLATION			
38287	<p>ABLATION OF ARRHYTHMIA CIRCUIT OR FOCUS or isolation procedure involving 1 atrial chamber (Anaes.) (Assist.)</p> <p>Fee: \$1,701.30 Benefit: 75% = \$1,276.00 85% = \$1,644.20</p>		
38290	<p>ABLATION OF ARRHYTHMIA CIRCUITS OR FOCI, or isolation procedure involving both atrial chambers and including curative procedures for atrial fibrillation (Anaes.) (Assist.)</p> <p>Fee: \$2,166.35 Benefit: 75% = \$1,624.80 85% = \$2,109.25</p>		
38293	<p>VENTRICULAR ARRHYTHMIA with mapping and ablation, including all associated electrophysiological studies performed on the same day (Anaes.) (Assist.)</p> <p>Fee: \$2,325.30 Benefit: 75% = \$1,744.00 85% = \$2,268.20</p>		

THORACIC SURGERY	
38400	THORACIC CAVITY, aspiration of, for diagnostic purposes, not being a service associated with a service to which item 38403 applies Fee: \$31.25 Benefit: 75% = \$23.45 85% = \$26.60
38403	THORACIC CAVITY, aspiration of, with therapeutic drainage (paracentesis), with or without diagnostic sample Fee: \$62.30 Benefit: 75% = \$46.75 85% = \$53.00
38406	PERICARDIUM, paracentesis of (excluding aftercare) (Anaes.) Fee: \$108.30 Benefit: 75% = \$81.25 85% = \$92.10
38409	INTERCOSTAL DRAIN, insertion of, not involving resection of rib (excluding aftercare) (Anaes.) Fee: \$108.30 Benefit: 75% = \$81.25 85% = \$92.10
38410	INTERCOSTAL DRAIN, insertion of, with pleurodesis and not involving resection of rib (excluding aftercare) (Anaes.) Fee: \$133.45 Benefit: 75% = \$100.10 85% = \$113.45
38412	PERCUTANEOUS NEEDLE BIOPSY of lung (Anaes.) Fee: \$169.60 Benefit: 75% = \$127.20 85% = \$144.20
38415	EMPHYEMA, radical operation for, involving resection of rib (Anaes.) (Assist.) Fee: \$323.75 Benefit: 75% = \$242.85 85% = \$275.20
38418	THORACOTOMY, exploratory, with or without biopsy (Anaes.) (Assist.) Fee: \$777.05 Benefit: 75% = \$582.80 85% = \$719.95
38421	THORACOTOMY, with pulmonary decortication (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00
38424	THORACOTOMY, with pleurectomy or pleurodesis, OR ENUCLEATION OF HYDATID cysts (Anaes.) (Assist.) Fee: \$777.05 Benefit: 75% = \$582.80 85% = \$719.95
38427	THORACOPLASTY (complete) - 3 or more ribs (Anaes.) (Assist.) Fee: \$959.45 Benefit: 75% = \$719.60 85% = \$902.35
38430	THORACOPLASTY (in stages) each stage (Anaes.) (Assist.) Fee: \$494.50 Benefit: 75% = \$370.90 85% = \$437.40
38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter, with or without biopsy (Anaes.) Fee: \$202.50 Benefit: 75% = \$151.90 85% = \$172.15
38438	PNEUMONECTOMY or LOBECTOMY or SEGMENTECTOMY not being a service associated with a service to which Item 38418 applies (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00
38440	LUNG, wedge resection of (Anaes.) (Assist.) Fee: \$930.15 Benefit: 75% = \$697.65 85% = \$873.05
38441	RADICAL LOBECTOMY or PNEUMONECTOMY including resection of chest wall, diaphragm, pericardium, or formal mediastinal node dissection (Anaes.) (Assist.) Fee: \$1,471.65 Benefit: 75% = \$1,103.75 85% = \$1,414.55
38446	THORACOTOMY or STERNOTOMY, for removal of thymus or mediastinal tumour (Anaes.) (Assist.) Fee: \$959.45 Benefit: 75% = \$719.60 85% = \$902.35
38447	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy without cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00
38448	MEDIASTINUM, cervical exploration of, with or without biopsy (Anaes.) (Assist.) Fee: \$294.35 Benefit: 75% = \$220.80 85% = \$250.20
38449	PERICARDIECTOMY via sternotomy or anterolateral thoracotomy with cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,737.70 Benefit: 75% = \$1,303.30 85% = \$1,680.60

OPERATIONS		CARDIO-THORACIC	
38450	PERICARDIUM, transthoracic drainage of (Anaes.) (Assist.) Fee: \$694.60 Benefit: 75% = \$520.95 85% = \$637.50		
38452	PERICARDIUM, sub-xyphoid drainage of (Anaes.) (Assist.) Fee: \$465.10 Benefit: 75% = \$348.85 85% = \$408.00		
38453	TRACHEAL excision and repair without cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,395.20 Benefit: 75% = \$1,046.40 85% = \$1,338.10		
38455	TRACHEAL EXCISION AND REPAIR OF, with cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,887.25 Benefit: 75% = \$1,415.45 85% = \$1,830.15		
38456	INTRATHORACIC OPERATION on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than 1 of those organs, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00		
38457	PECTUS EXCAVATUM or PECTUS CARINATUM, repair or radical correction of (Anaes.) (Assist.) Fee: \$1,159.65 Benefit: 75% = \$869.75 85% = \$1,102.55		
38458	PECTUS EXCAVATUM, repair of, with implantation of subcutaneous prosthesis (Anaes.) (Assist.) Fee: \$618.15 Benefit: 75% = \$463.65 85% = \$561.05		
38460	STERNAL WIRE OR WIRES, removal of (Anaes.) Fee: \$223.30 Benefit: 75% = \$167.50 85% = \$189.85		
38462	STERNOTOMY WOUND, debridement of, not involving reopening of the mediastinum (Anaes.) Fee: \$264.60 Benefit: 75% = \$198.45 85% = \$224.95		
38464	STERNOTOMY WOUND, debridement of, involving curettage of infected bone with or without removal of wires but not involving reopening of the mediastinum (Anaes.) Fee: \$287.65 Benefit: 75% = \$215.75 85% = \$244.55		
38466	STERNUM, reoperation on, for dehiscence or infection involving reopening of the mediastinum, with or without rewiring (Anaes.) (Assist.) Fee: \$776.80 Benefit: 75% = \$582.60 85% = \$719.70		
38468	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps or greater omentum (Anaes.) (Assist.) Fee: \$1,196.90 Benefit: 75% = \$897.70 85% = \$1,139.80		
38469	STERNUM AND MEDIASTINUM, reoperation for infection of, involving muscle advancement flaps and greater omentum (Anaes.) (Assist.) Fee: \$1,395.20 Benefit: 75% = \$1,046.40 85% = \$1,338.10		
PACEMAKER PROCEDURES			
38470	PERMANENT MYOCARDIAL ELECTRODE, insertion of, by thoracotomy or sternotomy (Anaes.) (Assist.) Fee: \$777.05 Benefit: 75% = \$582.80 85% = \$719.95		
38473	PERMANENT PACEMAKER ELECTRODE, insertion by sub-xyphoid approach (Anaes.) (Assist.) Fee: \$465.10 Benefit: 75% = \$348.85 85% = \$408.00		
VALVULAR PROCEDURES			
38475	VALVE ANNULOPLASTY without insertion of ring, not being a service associated with a service to which item 38480 or 38481 applies (Anaes.) (Assist.) Fee: \$674.45 Benefit: 75% = \$505.85 85% = \$617.35		
38477	VALVE ANNULOPLASTY with insertion of ring not being a service to which item 38478 applies (Anaes.) (Assist.) Fee: \$1,624.30 Benefit: 75% = \$1,218.25 85% = \$1,567.20		
38478	VALVE ANNULOPLASTY with insertion of ring performed in conjunction with item 38480 or 38481 (Anaes.) (Assist.) Fee: \$786.85 Benefit: 75% = \$590.15 85% = \$729.75		
38480	VALVE REPAIR, 1 leaflet (Anaes.) (Assist.) Fee: \$1,624.30 Benefit: 75% = \$1,218.25 85% = \$1,567.20		

OPERATIONS		CARDIO-THORACIC
38481	VALVE REPAIR, 2 or more leaflets (Anaes.) (Assist.) Fee: \$1,849.10 Benefit: 75% = \$1,386.85 85% = \$1,792.00	
38483	AORTIC VALVE LEAFLET OR LEAFLETS, decalcification of, not being a service to which item 38475 , 38477 , 38480 , 38481 , 38488 or 38489 applies (Anaes.) (Assist.) Fee: \$1,395.20 Benefit: 75% = \$1,046.40 85% = \$1,338.10	
38485	MITRAL ANNULUS, reconstruction of, after decalcification, when performed in association with valve surgery (Anaes.) (Assist.) Fee: \$662.55 Benefit: 75% = \$496.95 85% = \$605.45	
38487	MITRAL VALVE, open valvotomy of (Anaes.) (Assist.) Fee: \$1,395.20 Benefit: 75% = \$1,046.40 85% = \$1,338.10	
38488	VALVE REPLACEMENT with BIOPROSTHESIS OR MECHANICAL PROSTHESIS (Anaes.) (Assist.) Fee: \$1,548.25 Benefit: 75% = \$1,161.20 85% = \$1,491.15	
38489	VALVE REPLACEMENT with allograft (subcoronary or cylindrical implant), or unstented xenograft (Anaes.) (Assist.) Fee: \$1,841.25 Benefit: 75% = \$1,380.95 85% = \$1,784.15	
38490	SUB-VALVULAR STRUCTURES, reconstruction and re-implantation of, associated with mitral and tricuspid valve replacement (Anaes.) (Assist.) Fee: \$449.55 Benefit: 75% = \$337.20 85% = \$392.45	
38493	OPERATIVE MANAGEMENT of acute infective endocarditis, in association with heart valve surgery (Anaes.) (Assist.) Fee: \$1,587.20 Benefit: 75% = \$1,190.40 85% = \$1,530.10	
	<i>SURGERY FOR ISCHAEMIC HEART DISEASE</i>	
38496	ARTERY HARVESTING (other than internal mammary), for coronary artery bypass (Anaes.) (Assist.) Fee: \$505.85 Benefit: 75% = \$379.40 85% = \$448.75	
38497	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, not being a service associated with a service to which items 38498 , 38500 , 38501 , 38503 or 38504 apply (Anaes.) (Assist.) <i>(See para T8.45 of explanatory notes to this Category)</i> Fee: \$1,660.10 Benefit: 75% = \$1,245.10 85% = \$1,603.00	
38498	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass , using saphenous vein graft or grafts only, including harvesting of vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497 , 38500 , 38501 , 38503 , 38504 or 38600 apply (Anaes.) (Assist.) <i>(See para T8.45 of explanatory notes to this Category)</i> Fee: \$1,619.60 Benefit: 75% = \$1,214.70 85% = \$1,562.50	
38500	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497 , 38498 , 38501 , 38503 or 38504 apply (Anaes.) (Assist.) <i>(See para T8.45 of explanatory notes to this Category)</i> Fee: \$1,783.65 Benefit: 75% = \$1,337.75 85% = \$1,726.55	
38501	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass , using single arterial graft, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497 , 38498 , 38500 , 38503 , 38504 or 38600 apply (Anaes.) (Assist.) <i>(See para T8.45 of explanatory notes to this Category)</i> Fee: \$1,740.15 Benefit: 75% = \$1,305.15 85% = \$1,683.05	
38503	CORONARY ARTERY BYPASS with cardiopulmonary bypass, using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, not being a service associated with a service to which items 38497 , 38498 , 38500 , 38501 or 38504 apply (Anaes.) (Assist.) <i>(See para T8.45 of explanatory notes to this Category)</i> Fee: \$1,936.70 Benefit: 75% = \$1,452.55 85% = \$1,879.60	

OPERATIONS		CARDIO-THORACIC	
38504	CORONARY ARTERY BYPASS with the aid of tissue stabilisers, performed without cardiopulmonary bypass , using 2 or more arterial grafts, with or without vein graft or grafts, including harvesting of internal mammary artery or vein graft material where performed, either via a median sternotomy or other minimally invasive technique and where a stand-by perfusionist is present, not being a service associated with a service to which items 38497 , 38498 , 38500 , 38501 , 38503 or 38600 apply (Anaes.) (Assist.) (See para T8.45 of explanatory notes to this Category) Fee: \$1,889.45	Benefit: 75% = \$1,417.10	85% = \$1,832.35
38505	CORONARY ENDARTERECTOMY, by open operation, including repair with 1 or more patch grafts, each vessel (Anaes.) (Assist.) Fee: \$224.80	Benefit: 75% = \$168.60	85% = \$191.10
38506	LEFT VENTRICULAR ANEURYSM, plication of (Anaes.) (Assist.) Fee: \$1,318.55	Benefit: 75% = \$988.95	85% = \$1,261.45
38507	LEFT VENTRICULAR ANEURYSM resection with primary repair (Anaes.) (Assist.) Fee: \$1,547.95	Benefit: 75% = \$1,161.00	85% = \$1,490.85
38508	LEFT VENTRICULAR ANEURYSM resection with patch reconstruction of the left ventricle (Anaes.) (Assist.) Fee: \$1,936.70	Benefit: 75% = \$1,452.55	85% = \$1,879.60
38509	ISCHAEMIC VENTRICULAR SEPTAL RUPTURE, repair of (Anaes.) (Assist.) Fee: \$1,936.70	Benefit: 75% = \$1,452.55	85% = \$1,879.60
ARRHYTHMIA SURGERY			
38512	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving 1 atrial chamber only (Anaes.) (Assist.) Fee: \$1,701.30	Benefit: 75% = \$1,276.00	85% = \$1,644.20
38515	DIVISION OF ACCESSORY PATHWAY, isolation procedure, procedure on atrioventricular node or perinodal tissues involving both atrial chambers and including curative surgery for atrial fibrillation (Anaes.) (Assist.) Fee: \$2,166.35	Benefit: 75% = \$1,624.80	85% = \$2,109.25
38518	VENTRICULAR ARRHYTHMIA with mapping and muscle ablation, with or without aneurysmeotomy (Anaes.) (Assist.) Fee: \$2,325.30	Benefit: 75% = \$1,744.00	85% = \$2,268.20
38521	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.) (Assist.) Fee: \$853.50	Benefit: 75% = \$640.15	85% = \$796.40
38524	AUTOMATIC DEFIBRILLATOR GENERATOR, insertion or replacement of - not being a service associated with a service to which item 38213 applies (Anaes.) (Assist.) Fee: \$233.35	Benefit: 75% = \$175.05	85% = \$198.35
PROCEDURES ON THE THORACIC AORTA			
38550	ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) Fee: \$1,740.10	Benefit: 75% = \$1,305.10	85% = \$1,683.00
38553	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,205.10	Benefit: 75% = \$1,653.85	85% = \$2,148.00
38556	ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,517.15	Benefit: 75% = \$1,887.90	85% = \$2,460.05
38559	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, not involving valve replacement or repair or coronary artery implantation (Anaes.) (Assist.) Fee: \$2,052.10	Benefit: 75% = \$1,539.10	85% = \$1,995.00
38562	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, without implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,517.15	Benefit: 75% = \$1,887.90	85% = \$2,460.05

OPERATIONS		CARDIO-THORACIC	
38565	AORTIC ARCH and ASCENDING THORACIC AORTA, repair or replacement of, with aortic valve replacement or repair, and implantation of coronary arteries (Anaes.) (Assist.) Fee: \$2,823.25 Benefit: 75% = \$2,117.45 85% = \$2,766.15		
38568	DESCENDING THORACIC AORTA, repair or replacement of, without shunt or cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,510.45 Benefit: 75% = \$1,132.85 85% = \$1,453.35		
38571	DESCENDING THORACIC AORTA, repair or replacement of, using shunt or cardiopulmonary bypass (Anaes.) (Assist.) Fee: \$1,663.50 Benefit: 75% = \$1,247.65 85% = \$1,606.40		
38572	OPERATIVE MANAGEMENT OF ACUTE RUPTURE OR DISSECTION, in conjunction with procedures on the thoracic aorta (Anaes.) (Assist.) Fee: \$1,611.05 Benefit: 75% = \$1,208.30 85% = \$1,553.95		
38577	CANNULATION FOR, and supervision and monitoring of, the administration of retrograde cerebral perfusion during deep hypothermic arrest (Assist.) Fee: \$449.55 Benefit: 75% = \$337.20 85% = \$392.45		
TECHNIQUES FOR PRESERVATION OF THE ARRESTED HEART			
38588	CANNULATION of the coronary sinus for, and supervision of, the retrograde administration of blood or crystalloid for cardioplegia, including pressure monitoring (Assist.) Fee: \$337.30 Benefit: 75% = \$253.00 85% = \$286.75		
CIRCULATORY SUPPORT PROCEDURES			
38600	CENTRAL CANNULATION for cardiopulmonary bypass excluding post-operative management, not being a service associated with a service to which another item in this Subgroup applies (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00		
38603	PERIPHERAL CANNULATION for cardiopulmonary bypass excluding post-operative management (Anaes.) (Assist.) Fee: \$777.05 Benefit: 75% = \$582.80 85% = \$719.95		
38606	INTRA-AORTIC BALLOON PUMP, percutaneous insertion of (Anaes.) Fee: \$312.05 Benefit: 75% = \$234.05 85% = \$265.25		
38609	INTRA-AORTIC BALLOON PUMP, insertion of, by arteriotomy (Anaes.) (Assist.) Fee: \$388.50 Benefit: 75% = \$291.40 85% = \$331.40		
38612	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by direct suture (Anaes.) (Assist.) Fee: \$435.50 Benefit: 75% = \$326.65 85% = \$378.40		
38613	INTRA-AORTIC BALLOON PUMP, removal of, with closure of artery by patch graft (Anaes.) (Assist.) Fee: \$546.60 Benefit: 75% = \$409.95 85% = \$489.50		
38615	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00		
38618	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, insertion of (Anaes.) (Assist.) Fee: \$1,548.25 Benefit: 75% = \$1,161.20 85% = \$1,491.15		
38621	LEFT OR RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$618.15 Benefit: 75% = \$463.65 85% = \$561.05		
38624	LEFT AND RIGHT VENTRICULAR ASSIST DEVICE, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$694.60 Benefit: 75% = \$520.95 85% = \$637.50		
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.) (Assist.) Fee: \$542.90 Benefit: 75% = \$407.20 85% = \$485.80		
RE-OPERATION			
38637	PATENT DISEASED coronary artery bypass vein graft or grafts, dissection, disconnection and oversewing of (Anaes.) (Assist.) Fee: \$449.55 Benefit: 75% = \$337.20 85% = \$392.45		

OPERATIONS		CARDIO-THORACIC
38640	RE-OPERATION via median sternotomy, for any procedure, including any divisions of adhesions where the time taken to divide the adhesions is 45 minutes or less (Anaes.) (Assist.) (See para T8.46 of explanatory notes to this Category) Fee: \$777.05 Benefit: 75% = \$582.80 85% = \$719.95	
MISCELLANEOUS PROCEDURES		
38643	THORACOTOMY OR STERNOTOMY involving division of adhesions where the time taken to divide the adhesions exceeds 45 minutes (Anaes.) (Assist.) Fee: \$865.35 Benefit: 75% = \$649.05 85% = \$808.25	
38647	THORACOTOMY OR STERNOTOMY involving division of extensive adhesions where the time taken to divide the adhesions exceeds 2 hours (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38650	MYOMECTOMY or MYOTOMY for hypertrophic obstructive cardiomyopathy (Anaes.) (Assist.) Fee: \$1,548.25 Benefit: 75% = \$1,161.20 85% = \$1,491.15	
38653	OPEN HEART SURGERY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,548.25 Benefit: 75% = \$1,161.20 85% = \$1,491.15	
38656	THORACOTOMY or median sternotomy for post-operative bleeding (Anaes.) (Assist.) Fee: \$777.05 Benefit: 75% = \$582.80 85% = \$719.95	
CARDIAC TUMOURS		
38670	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, without patch or conduit reconstruction (Anaes.) (Assist.) Fee: \$1,547.95 Benefit: 75% = \$1,161.00 85% = \$1,490.85	
38673	CARDIAC TUMOUR, excision of, involving the wall of the atrium or inter-atrial septum, requiring reconstruction with patch or conduit (Anaes.) (Assist.) Fee: \$1,742.30 Benefit: 75% = \$1,306.75 85% = \$1,685.20	
38677	CARDIAC TUMOUR arising from ventricular myocardium, partial thickness excision of (Anaes.) (Assist.) Fee: \$1,629.90 Benefit: 75% = \$1,222.45 85% = \$1,572.80	
38680	CARDIAC TUMOUR arising from ventricular myocardium, full thickness excision of including repair or reconstruction (Anaes.) (Assist.) Fee: \$1,933.35 Benefit: 75% = \$1,450.05 85% = \$1,876.25	
CONGENITAL CARDIAC SURGERY		
38700	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$865.35 Benefit: 75% = \$649.05 85% = \$808.25	
38703	PATENT DUCTUS ARTERIOSUS, shunt, collateral or other single large vessel, division or ligation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,560.00 Benefit: 75% = \$1,170.00 85% = \$1,502.90	
38706	AORTA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,477.55 Benefit: 75% = \$1,108.20 85% = \$1,420.45	
38709	AORTA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38712	AORTIC INTERRUPTION, repair of, for congenital heart disease (Anaes.) (Assist.) Fee: \$2,078.10 Benefit: 75% = \$1,558.60 85% = \$2,021.00	
38715	MAIN PULMONARY ARTERY, banding, debanding or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,383.40 Benefit: 75% = \$1,037.55 85% = \$1,326.30	
38718	MAIN PULMONARY ARTERY, banding, debanding or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	

OPERATIONS		CARDIO-THORACIC
38721	VENA CAVA, anastomosis or repair of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,212.70 Benefit: 75% = \$909.55 85% = \$1,155.60	
38724	VENA CAVA, anastomosis or repair of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38727	INTRATHORACIC VESSELS, anastomosis or repair of, without cardiopulmonary bypass, not being a service to which item 38700 , 38703 , 38706 , 38709 , 38712 , 38715 , 38718 , 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,212.70 Benefit: 75% = \$909.55 85% = \$1,155.60	
38730	INTRATHORACIC VESSELS, anastomosis or repair of, with cardiopulmonary bypass, not being a service to which item 38700 , 38703 , 38706 , 38709 , 38712 , 38715 , 38718 , 38721 or 38724 applies, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38733	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,212.70 Benefit: 75% = \$909.55 85% = \$1,155.60	
38736	SYSTEMIC PULMONARY or CAVO-PULMONARY SHUNT, creation of, with cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38739	ATRIAL SEPTECTOMY, with or without cardiopulmonary bypass, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,560.00 Benefit: 75% = \$1,170.00 85% = \$1,502.90	
38742	ATRIAL SEPTAL DEFECT, closure by open exposure direct suture or patch, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,560.00 Benefit: 75% = \$1,170.00 85% = \$1,502.90	
38745	INTRA-ATRIAL BAFFLE, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38748	VENTRICULAR SEPTECTOMY, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38751	VENTRICULAR SEPTAL DEFECT, closure by direct suture or patch, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38754	INTRAVENTRICULAR BAFFLE OR CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$2,166.35 Benefit: 75% = \$1,624.80 85% = \$2,109.25	
38757	EXTRACARDIAC CONDUIT, insertion of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38760	EXTRACARDIAC CONDUIT, replacement of, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38763	VENTRICULAR MYECTOMY, for relief of ventricular obstruction, right or left, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	
38766	VENTRICULAR AUGMENTATION, right or left, for congenital heart disease (Anaes.) (Assist.) Fee: \$1,730.65 Benefit: 75% = \$1,298.00 85% = \$1,673.55	

OPERATIONS		NEUROSURGICAL	
GROUP T8 - SURGICAL OPERATIONS			
SUBGROUP 7 - NEUROSURGICAL			
GENERAL			
39000	LUMBAR PUNCTURE (Anaes.) Fee: \$61.05	Benefit: 75% = \$45.80	85% = \$51.90
39003	CISTERNAL PUNCTURE (Anaes.) Fee: \$69.45	Benefit: 75% = \$52.10	85% = \$59.05
39006	VENTRICULAR PUNCTURE (not including burr-hole) (Anaes.) Fee: \$129.25	Benefit: 75% = \$96.95	85% = \$109.90
39009	SUBDURAL HAEMORRHAGE, tap for, each tap (Anaes.) Fee: \$48.10	Benefit: 75% = \$36.10	85% = \$40.90
39012	BURR-HOLE, single, preparatory to ventricular puncture or for inspection purpose - not being a service to which another item applies (Anaes.) Fee: \$192.65	Benefit: 75% = \$144.50	85% = \$163.80
39013	INJECTION UNDER IMAGE INTENSIFICATION with 1 or more of contrast media, local anaesthetic or corticosteroid into 1 or more zygo-apophyseal or costo-transverse joints or 1 or more primary posterior rami of spinal nerves (Anaes.) Fee: \$88.55	Benefit: 75% = \$66.45	85% = \$75.30
39015	VENTRICULAR RESERVOIR, EXTERNAL VENTRICULAR DRAIN or INTRACRANIAL PRESSURE MONITORING DEVICE, insertion of - including burr-hole (excluding after-care) (Anaes.) (Assist.) Fee: \$304.85	Benefit: 75% = \$228.65	85% = \$259.15
39018	CEREBROSPINAL FLUID reservoir, insertion of (Anaes.) (Assist.) Fee: \$304.85	Benefit: 75% = \$228.65	85% = \$259.15
PROCEDURES FOR PAIN RELIEF			
39100	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) Fee: \$192.65	Benefit: 75% = \$144.50	85% = \$163.80
39106	NEURECTOMY, INTRACRANIAL, for trigeminal neuralgia (Anaes.) (Assist.) Fee: \$963.35	Benefit: 75% = \$722.55	85% = \$906.25
39109	TRIGEMINAL GANGLIOTOMY by radiofrequency, balloon or glycerol (Anaes.) Fee: \$359.70	Benefit: 75% = \$269.80	85% = \$305.75
39112	CRANIAL NERVE, intracranial decompression of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$1,249.90	Benefit: 75% = \$937.45	85% = \$1,192.80
39115	PERCUTANEOUS NEUROTOMY of posterior divisions (or rami) of spinal nerves by any method, including any associated spinal, epidural or regional nerve block (payable once only in a 30 day period) (Anaes.) Fee: \$61.05	Benefit: 75% = \$45.80	85% = \$51.90
39118	PERCUTANEOUS NEUROTOMY for facet joint denervation by radio-frequency probe or cryoprobe using radiological imaging control (Anaes.) (Assist.) Fee: \$241.45	Benefit: 75% = \$181.10	85% = \$205.25
39121	PERCUTANEOUS CORDOTOMY (Anaes.) (Assist.) Fee: \$512.20	Benefit: 75% = \$384.15	85% = \$455.10
39124	CORDOTOMY OR MYELOTOMY, laminectomy for, or operation for dorsal root entry zone (Drez) lesion (Anaes.) (Assist.) Fee: \$1,310.85	Benefit: 75% = \$983.15	85% = \$1,253.75
39125	SPINAL CATHETER, insertion of - for an automated infusion device (Anaes.) (Assist.) Fee: \$241.65	Benefit: 75% = \$181.25	85% = \$205.45
39126	AUTOMATED SUBCUTANEOUS INFUSION DEVICE, insertion of (Anaes.) (Assist.) Fee: \$293.40	Benefit: 75% = \$220.05	85% = \$249.40

OPERATIONS		NEUROSURGICAL
39127	SUBCUTANEOUS RESERVOIR AND SPINAL CATHETER FOR PAIN, insertion of (Anaes.) Fee: \$384.05 Benefit: 75% = \$288.05 85% = \$326.95	
39128	AUTOMATED SUBCUTANEOUS INFUSION DEVICE AND SPINAL CATHETER, insertion of (Anaes.) (Assist.) Fee: \$535.05 Benefit: 75% = \$401.30 85% = \$477.95	
39130	PERCUTANEOUS EPIDURAL ELECTRODE, insertion of 1 or more of - for spinal stimulation (Anaes.) Fee: \$494.80 Benefit: 75% = \$371.10 85% = \$437.70	
39131	PERCUTANEOUS EPIDURAL ELECTRODES, management, adjustment, electronic programming and trial of stimulation of, by a medical practitioner - each day Fee: \$103.65 Benefit: 75% = \$77.75 85% = \$88.15	
39133	EPIDURAL STIMULATOR or INTRATHECAL INFUSION DEVICE, revision of (Anaes.) Fee: \$129.25 Benefit: 75% = \$96.95 85% = \$109.90	
39134	SPINAL NEUROSTIMULATOR RECEIVER or pulse generator, subcutaneous placement of, not being a service associated with deep brain stimulation for Parkinson's disease (Anaes.) (Assist.) Fee: \$276.15 Benefit: 75% = \$207.15 85% = \$234.75	
39136	PERCUTANEOUS EPIDURAL IMPLANT for management of pain, removal of (Anaes.) Fee: \$129.25 Benefit: 75% = \$96.95 85% = \$109.90	
39139	EPIDURAL ELECTRODE for management of pain, insertion of 1 or more of by laminectomy, including implantation of pulse generator (1 or 2 stages) (Anaes.) (Assist.) Fee: \$871.90 Benefit: 75% = \$653.95 85% = \$814.80	
39140	EPIDURAL CATHETER, insertion of, under imaging control, with epidurogram and epidural therapeutic injection for lysis of adhesions (Anaes.) Fee: \$237.45 Benefit: 75% = \$178.10 85% = \$201.85	
PERIPHERAL NERVES		
39300	CUTANEOUS NERVE (including digital nerve), primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60	
39303	CUTANEOUS NERVE (including digital nerve), secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$377.90 Benefit: 75% = \$283.45 85% = \$321.25	
39306	NERVE TRUNK, primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$548.80 Benefit: 75% = \$411.60 85% = \$491.70	
39309	NERVE TRUNK, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$579.15 Benefit: 75% = \$434.40 85% = \$522.05	
39312	NERVE TRUNK, (interfascicular), neurolysis of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$323.10 Benefit: 75% = \$242.35 85% = \$274.65	
39315	NERVE TRUNK, nerve graft to, (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) Fee: \$835.20 Benefit: 75% = \$626.40 85% = \$778.10	
39318	CUTANEOUS NERVE (including digital nerve), nerve graft to, using microsurgical techniques (Anaes.) (Assist.) Fee: \$518.25 Benefit: 75% = \$388.70 85% = \$461.15	
39321	NERVE, transposition of (Anaes.) (Assist.) Fee: \$384.05 Benefit: 75% = \$288.05 85% = \$326.95	
39323	PERCUTANEOUS NEUROTOMY by cryoneurotomy or radiofrequency lesion generator, not being a service to which another item applies (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70	
39324	NEURECTOMY, NEUROTOMY or removal of tumour from superficial peripheral nerve, by open operation (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70	
39327	NEURECTOMY, NEUROTOMY or removal of tumour from deep peripheral nerve, by open operation (Anaes.) (Assist.) Fee: \$384.05 Benefit: 75% = \$288.05 85% = \$326.95	

OPERATIONS		NEUROSURGICAL	
39330	NEUROLYSIS by open operation without transposition, not being a service associated with a service to which item 39312 applies (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70		
39331	CARPAL TUNNEL RELEASE (division of transverse carpal ligament), by any method (Anaes.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70		
39333	BRACHIAL PLEXUS, exploration of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$323.10 Benefit: 75% = \$242.35 85% = \$274.65		
CRANIAL NERVES			
39500	VESTIBULAR NERVE, section of, via posterior fossa (Anaes.) (Assist.) Fee: \$1,030.45 Benefit: 75% = \$772.85 85% = \$973.35		
39503	FACIO-HYPOGLOSSAL nerve or FACIO-ACCESSORY nerve, anastomosis of (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20		
CRANIO-CEREBRAL INJURIES			
39600	INTRACRANIAL HAEMORRHAGE, burr-hole craniotomy for - including burr-holes (Anaes.) (Assist.) Fee: \$384.05 Benefit: 75% = \$288.05 85% = \$326.95		
39603	INTRACRANIAL HAEMORRHAGE, osteoplastic craniotomy or extensive craniectomy and removal of haematoma (Anaes.) (Assist.) Fee: \$969.40 Benefit: 75% = \$727.05 85% = \$912.30		
39606	FRACTURED SKULL, depressed or comminuted, operation for (Anaes.) (Assist.) Fee: \$646.25 Benefit: 75% = \$484.70 85% = \$589.15		
39609	FRACTURED SKULL, compound, without dural penetration, operation for (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20		
39612	FRACTURED SKULL, compound, depressed or complicated, with dural penetration and brain laceration, operation for (Anaes.) (Assist.) Fee: \$908.50 Benefit: 75% = \$681.40 85% = \$851.40		
39615	FRACTURED SKULL with rhinorrhoea or otorrhoea, cranioplasty and repair of (Anaes.) (Assist.) Fee: \$969.40 Benefit: 75% = \$727.05 85% = \$912.30		
SKULL BASE SURGERY			
39640	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving craniotomy, radical excision of the skull base, and dural repair (Anaes.) (Assist.) <i>(See para T8.47 of explanatory notes to this Category)</i> Fee: \$2,458.00 Benefit: 75% = \$1,843.50 85% = \$2,400.90		
39642	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy for clearance of paranasal sinus extension (intracranial procedure) (Anaes.) (Assist.) <i>(See para T8.47 of explanatory notes to this Category)</i> Fee: \$2,584.15 Benefit: 75% = \$1,938.15 85% = \$2,527.05		
39646	TUMOUR INVOLVING ANTERIOR CRANIAL FOSSA, removal of, involving frontal craniotomy with lateral rhinotomy and radical clearance of paranasal sinus and orbital fossa extensions, with intracranial decompression of the optic nerve, (intracranial procedure) (Anaes.) (Assist.) <i>(See para T8.47 of explanatory notes to this Category)</i> Fee: \$2,962.25 Benefit: 75% = \$2,221.70 85% = \$2,905.15		
39650	TUMOUR INVOLVING MIDDLE CRANIAL FOSSA AND INFRA-TEMPORAL FOSSA, removal of, craniotomy and radical or sub-total radical excision, with division and reconstruction of zygomatic arch, (intracranial procedure) (Anaes.) (Assist.) <i>(See para T8.47 of explanatory notes to this Category)</i> Fee: \$2,142.85 Benefit: 75% = \$1,607.15 85% = \$2,085.75		
39653	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision (intracranial procedure), not being a service to which item 39654 or 39656 applies (Anaes.) (Assist.) <i>(See para T8.47 of explanatory notes to this Category)</i> Fee: \$3,813.10 Benefit: 75% = \$2,859.85 85% = \$3,756.00		

OPERATIONS		NEUROSURGICAL	
39654	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure), conjoint surgery, principal surgeon (Anaes.) (Assist.) (See para T8.47 of explanatory notes to this Category) Fee: \$2,773.20 Benefit: 75% = \$2,079.90 85% = \$2,716.10		
39656	PETRO-CLIVAL AND CLIVAL TUMOUR, removal of, by supra and infratentorial approaches for radical or sub-total radical excision, (intracranial procedure) conjoint surgery, co-surgeon (Assist.) (See para T8.47 of explanatory notes to this Category) Fee: \$2,079.90 Benefit: 75% = \$1,559.95 85% = \$2,022.80		
39658	TUMOUR INVOLVING THE CLIVUS, radical or sub-total radical excision of, involving transoral or transmaxillary approach (Anaes.) (Assist.) (See para T8.47 of explanatory notes to this Category) Fee: \$2,458.00 Benefit: 75% = \$1,843.50 85% = \$2,400.90		
39660	TUMOUR OR VASCULAR LESION OF CAVERNOUS SINUS, radical excision of, involving craniotomy with or without intracranial carotid artery exposure (Anaes.) (Assist.) (See para T8.47 of explanatory notes to this Category) Fee: \$2,458.00 Benefit: 75% = \$1,843.50 85% = \$2,400.90		
39662	TUMOUR OR VASCULAR LESION OF FORAMEN MAGNUM, radical excision of, via transcondylar or far lateral suboccipital approach (Anaes.) (Assist.) (See para T8.47 of explanatory notes to this Category) Fee: \$2,458.00 Benefit: 75% = \$1,843.50 85% = \$2,400.90		
INTRACRANIAL NEOPLASMS			
39700	SKULL TUMOUR, benign or malignant, excision of, excluding cranioplasty (Anaes.) (Assist.) Fee: \$451.30 Benefit: 75% = \$338.50 85% = \$394.20		
39703	INTRACRANIAL tumour, cyst or other brain tissue, burr-hole and biopsy of, or drainage of, or both (Anaes.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60		
39706	INTRACRANIAL tumour, biopsy or decompression of via osteoplastic flap OR biopsy and decompression of via osteoplastic flap (Anaes.) (Assist.) Fee: \$902.25 Benefit: 75% = \$676.70 85% = \$845.15		
39709	CRANIOTOMY for removal of glioma, metastatic carcinoma or any other tumour in cerebrum, cerebellum or brain stem - not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35		
39712	CRANIOTOMY FOR REMOVAL OF MENINGIOMA, pinealoma, cranio-pharyngioma, intraventricular tumour or any other intracranial tumour, not being a service to which another item in this Sub-group applies (Anaes.) (Assist.) Fee: \$2,322.90 Benefit: 75% = \$1,742.20 85% = \$2,265.80		
39715	PITUITARY TUMOUR, removal of, by transcranial or transphenoidal approach (Anaes.) (Assist.) Fee: \$1,609.60 Benefit: 75% = \$1,207.20 85% = \$1,552.50		
39718	ARACHNOIDAL CYST, craniotomy for (Anaes.) (Assist.) Fee: \$707.25 Benefit: 75% = \$530.45 85% = \$650.15		
39721	CRANIOTOMY, involving osteoplastic flap, for re-opening post-operatively for haemorrhage, swelling, etc (Anaes.) (Assist.) Fee: \$646.25 Benefit: 75% = \$484.70 85% = \$589.15		
CEREBROVASCULAR DISEASE			
39800	ANEURYSM, clipping or reinforcement of sac (Anaes.) (Assist.) Fee: \$2,316.85 Benefit: 75% = \$1,737.65 85% = \$2,259.75		
39803	INTRACRANIAL ARTERIOVENOUS MALFORMATION, excision of (Anaes.) (Assist.) Fee: \$2,316.85 Benefit: 75% = \$1,737.65 85% = \$2,259.75		
39806	ANEURYSM, or arteriovenous malformation, intracranial proximal artery clipping of (Anaes.) (Assist.) Fee: \$1,042.55 Benefit: 75% = \$781.95 85% = \$985.45		

OPERATIONS		NEUROSURGICAL	
39812	INTRACRANIAL ANEURYSM or arteriovenous fistula, ligation of cervical vessel or vessels (Anaes.) (Assist.) Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
39815	CAROTID-CAVERNOUS FISTULA, obliteration of - combined cervical and intracranial procedure (Anaes.) (Assist.) Fee: \$1,481.50 Benefit: 75% = \$1,111.15 85% = \$1,424.40		
39818	EXTRACRANIAL TO INTRACRANIAL BYPASS using superficial temporal artery (Anaes.) (Assist.) Fee: \$1,481.50 Benefit: 75% = \$1,111.15 85% = \$1,424.40		
39821	EXTRACRANIAL TO INTRACRANIAL BYPASS using saphenous vein graft (Anaes.) (Assist.) Fee: \$1,759.20 Benefit: 75% = \$1,319.40 85% = \$1,702.10		
INFECTION			
39900	INTRACRANIAL INFECTION, drainage of, via burr-hole - including burr-hole (Anaes.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60		
39903	INTRACRANIAL ABSCESS, excision of (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35		
39906	OSTEOMYELITIS OF SKULL or removal of infected bone flap, craniectomy for (Anaes.) (Assist.) Fee: \$646.25 Benefit: 75% = \$484.70 85% = \$589.15		
CEREBRO-SPINAL FLUID CIRCULATION DISORDERS			
40000	VENTRICULO-CISTERNOSTOMY (Torkildsen's operation) (Anaes.) (Assist.) Fee: \$743.85 Benefit: 75% = \$557.90 85% = \$686.75		
40003	CRANIAL OR CISTERNAL SHUNT DIVERSION, insertion of (Anaes.) (Assist.) Fee: \$743.85 Benefit: 75% = \$557.90 85% = \$686.75		
40006	LUMBAR SHUNT DIVERSION, insertion of (Anaes.) (Assist.) Fee: \$585.30 Benefit: 75% = \$439.00 85% = \$528.20		
40009	CRANIAL, CISTERNAL OR LUMBAR SHUNT, revision or removal of (Anaes.) (Assist.) Fee: \$426.75 Benefit: 75% = \$320.10 85% = \$369.65		
40012	THIRD VENTRICULOSTOMY (open or endoscopic) with or without endoscopic septum pellucidotomy (Anaes.) (Assist.) Fee: \$835.20 Benefit: 75% = \$626.40 85% = \$778.10		
40015	SUBTEMPORAL DECOMPRESSION (Anaes.) (Assist.) Fee: \$517.85 Benefit: 75% = \$388.40 85% = \$460.75		
40018	LUMBAR CEREBROSPINAL FLUID DRAIN, insertion of (Anaes.) Fee: \$129.25 Benefit: 75% = \$96.95 85% = \$109.90		
CONGENITAL DISORDERS			
40100	MENINGOCELE, excision and closure of (Anaes.) (Assist.) Fee: \$560.95 Benefit: 75% = \$420.75 85% = \$503.85		
40103	MYELOMENINGOCELE, excision and closure of, including skin flaps or Z plasty where performed (Anaes.) (Assist.) Fee: \$823.10 Benefit: 75% = \$617.35 85% = \$766.00		
40106	ARNOLD-CHIARI MALFORMATION, decompression of (Anaes.) (Assist.) Fee: \$835.20 Benefit: 75% = \$626.40 85% = \$778.10		
40109	ENCEPHALOCOELE, excision and closure of (Anaes.) (Assist.) Fee: \$902.25 Benefit: 75% = \$676.70 85% = \$845.15		
40112	TETHERED CORD, release of, including lipomeningocele or diastematomyelia (Anaes.) (Assist.) Fee: \$1,158.40 Benefit: 75% = \$868.80 85% = \$1,101.30		
40115	CRANIOSTENOSIS, operation for - single suture (Anaes.) (Assist.) Fee: \$585.30 Benefit: 75% = \$439.00 85% = \$528.20		

OPERATIONS		NEUROSURGICAL
40118	CRANIOSTENOSIS, operation for - more than 1 suture (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20	
SPINAL DISORDERS		
40300	INTERVERTEBRAL DISC OR DISCS, laminectomy for removal of (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20	
40301	INTERVERTEBRAL DISC OR DISCS, microsurgical discectomy of (Anaes.) (Assist.) Fee: \$776.80 Benefit: 75% = \$582.60 85% = \$719.70	
40303	RECURRENT DISC LESION OR SPINAL STENOSIS, or both, laminectomy for - 1 level (Anaes.) (Assist.) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90	
40306	SPINAL STENOSIS, laminectomy for, involving more than 1 vertebral interspace (disc level) (Anaes.) (Assist.) Fee: \$1,164.55 Benefit: 75% = \$873.45 85% = \$1,107.45	
40309	EXTRADURAL TUMOUR OR ABSCESS, laminectomy for (Anaes.) (Assist.) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90	
40312	INTRADURAL LESION, laminectomy for, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$1,188.85 Benefit: 75% = \$891.65 85% = \$1,131.75	
40315	CRANIOCERVICAL JUNCTION LESION, transoral approach for (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35	
40316	ODONTOID screw fixation (Anaes.) (Assist.) Fee: \$1,686.15 Benefit: 75% = \$1,264.65 85% = \$1,629.05	
40318	INTRAMEDULLARY TUMOUR OR ARTERIOVENOUS MALFORMATION, laminectomy and radical excision of (Anaes.) (Assist.) Fee: \$1,609.60 Benefit: 75% = \$1,207.20 85% = \$1,552.50	
40321	POSTERIOR SPINAL FUSION, not being a service to which items 40324 and 40327 apply (Anaes.) (Assist.) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90	
40324	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - laminectomy, including aftercare (Anaes.) (Assist.) Fee: \$518.25 Benefit: 75% = \$388.70 85% = \$461.15	
40327	LAMINECTOMY FOLLOWED BY POSTERIOR FUSION, performed by neurosurgeon and orthopaedic surgeon operating together - posterior fusion, including aftercare (Assist.) Fee: \$518.25 Benefit: 75% = \$388.70 85% = \$461.15	
40330	SPINAL RHIZOLYSIS involving exposure of spinal nerve roots - for lateral recess, exit foraminal stenosis, adhesive radiculopathy or extensive epidural fibrosis, at 1 or more levels - with or without laminectomy (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20	
40331	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20	
40332	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, 1 level, not being a service to which item 40330 applies (Anaes.) (Assist.) Fee: \$1,263.45 Benefit: 75% = \$947.60 85% = \$1,206.35	
40333	CERVICAL DISCECTOMY (ANTERIOR), without fusion (Anaes.) (Assist.) Fee: \$646.25 Benefit: 75% = \$484.70 85% = \$589.15	
40334	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, without fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) Fee: \$854.40 Benefit: 75% = \$640.80 85% = \$797.30	
40335	CERVICAL DECOMPRESSION of spinal cord with or without involvement of nerve roots, including anterior fusion, more than 1 level, by any approach, not being a service to which item 40330 applies (Anaes.) (Assist.) Fee: \$1,569.20 Benefit: 75% = \$1,176.90 85% = \$1,512.10	

OPERATIONS		EAR, NOSE AND THROAT	
40336	INTRADISCAL INJECTION OF CHYMOPAPAIN (DISCAGE) - 1 disc (Anaes.) (Assist.) <i>(See para T8.48 of explanatory notes to this Category)</i> Fee: \$256.15 Benefit: 75% = \$192.15 85% = \$217.75		
40339	HYDROMYELIA, plugging of obex for, with or without duroplasty (Anaes.) (Assist.) Fee: \$1,286.45 Benefit: 75% = \$964.85 85% = \$1,229.35		
40342	HYDROMYELIA, craniotomy and laminectomy for, with cavity packing and CSF shunt (Anaes.) (Assist.) Fee: \$1,188.85 Benefit: 75% = \$891.65 85% = \$1,131.75		
40345	THORACIC DECOMPRESSION of spinal cord with or without involvement of nerve roots, via pedicle or costotransversectomy (Anaes.) (Assist.) Fee: \$1,106.80 Benefit: 75% = \$830.10 85% = \$1,049.70		
40348	THORACIC DECOMPRESSION of spinal cord via thoracotomy with vertebrectomy, not including stabilisation procedure (Anaes.) (Assist.) Fee: \$1,405.10 Benefit: 75% = \$1,053.85 85% = \$1,348.00		
40351	THORACO-LUMBAR or high lumbar anterior decompression of spinal cord, not including stabilisation procedure (Anaes.) (Assist.) Fee: \$1,405.10 Benefit: 75% = \$1,053.85 85% = \$1,348.00		
SKULL RECONSTRUCTION			
40600	CRANIOPLASTY, reconstructive (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20		
EPILEPSY			
40700	CORPUS CALLOSUM, anterior section of, for epilepsy (Anaes.) (Assist.) Fee: \$1,414.55 Benefit: 75% = \$1,060.95 85% = \$1,357.45		
40703	CORTICECTOMY, TOPECTOMY or PARTIAL LOBECTOMY for epilepsy (Anaes.) (Assist.) Fee: \$1,188.85 Benefit: 75% = \$891.65 85% = \$1,131.75		
40706	HEMISPHERECTOMY for intractable epilepsy (Anaes.) (Assist.) Fee: \$1,737.60 Benefit: 75% = \$1,303.20 85% = \$1,680.50		
40709	BURR-HOLE PLACEMENT of intracranial depth or surface electrodes (Anaes.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60		
40712	INTRACRANIAL ELECTRODE PLACEMENT via craniotomy (Anaes.) (Assist.) Fee: \$847.40 Benefit: 75% = \$635.55 85% = \$790.30		
STEREOTACTIC PROCEDURES			
40800	STEREOTACTIC ANATOMICAL LOCALISATION, as an independent procedure (Anaes.) (Assist.) Fee: \$517.85 Benefit: 75% = \$388.40 85% = \$460.75		
40801	FUNCTIONAL STEREOTACTIC procedure including computer assisted anatomical localisation, physiological localisation, and lesion production in the basal ganglia, brain stem or deep white matter tracts, not being a service associated with deep brain stimulation for Parkinson's disease (Anaes.) (Assist.) Fee: \$1,415.40 Benefit: 75% = \$1,061.55 85% = \$1,358.30		
40803	INTRACRANIAL STEREOTACTIC PROCEDURE BY ANY METHOD, not being a service to which item 40800 or 40801 applies (Anaes.) (Assist.) Fee: \$969.40 Benefit: 75% = \$727.05 85% = \$912.30		
MISCELLANEOUS			
40903	NEUROENDOSCOPY, for inspection of an intraventricular lesion, with or without biopsy including burr hole (Anaes.) (Assist.) Fee: \$449.55 Benefit: 75% = \$337.20 85% = \$392.45		

OPERATIONS		EAR, NOSE AND THROAT	
SUBGROUP 8 - EAR, NOSE AND THROAT			
41500	EAR, foreign body (other than ventilating tube) in, removal of, other than by simple syringing (Anaes.) (See para T8.49 of explanatory notes to this Category) Fee: \$66.90	Benefit: 75% = \$50.20	85% = \$56.90
41503	EAR, foreign body in, removal of, involving incision of external auditory canal (Anaes.) Fee: \$193.65	Benefit: 75% = \$145.25	85% = \$164.65
41506	AURAL POLYP, removal of (Anaes.) Fee: \$116.80	Benefit: 75% = \$87.60	85% = \$99.30
41509	EXTERNAL AUDITORY MEATUS, surgical removal of keratosis obturans from, not being a service to which another item in this Group applies (Anaes.) Fee: \$132.15	Benefit: 75% = \$99.15	85% = \$112.35
41512	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, not being a service to which item 41515 applies (Anaes.) (Assist.) Fee: \$475.05	Benefit: 75% = \$356.30	85% = \$417.95
41515	MEATOPLASTY involving removal of cartilage or bone or both cartilage and bone, being a service associated with a service to which item 41530 , 41548 , 41557 , 41560 or 41563 applies (Anaes.) (Assist.) (See para T8.50 of explanatory notes to this Category) Fee: \$311.75	Benefit: 75% = \$233.85	85% = \$265.00
41518	EXTERNAL AUDITORY MEATUS, removal of EXOSTOSES IN (Anaes.) (Assist.) Fee: \$753.00	Benefit: 75% = \$564.75	85% = \$695.90
41521	Correction of AUDITORY CANAL STENOSIS, including meatoplasty, with or without grafting (Anaes.) (Assist.) Fee: \$801.75	Benefit: 75% = \$601.35	85% = \$744.65
41524	RECONSTRUCTION OF EXTERNAL AUDITORY CANAL, being a service associated with a service to which items 41557 , 41560 and 41563 apply (Anaes.) (Assist.) (See para T8.51 of explanatory notes to this Category) Fee: \$231.60	Benefit: 75% = \$173.70	85% = \$196.90
41527	MYRINGOPLASTY, transcanal approach (Rosen incision) (Anaes.) (Assist.) Fee: \$476.45	Benefit: 75% = \$357.35	85% = \$419.35
41530	MYRINGOPLASTY, postaural or endaural approach with or without mastoid inspection (Anaes.) Fee: \$776.15	Benefit: 75% = \$582.15	85% = \$719.05
41533	ATTICOTOMY without reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) Fee: \$927.85	Benefit: 75% = \$695.90	85% = \$870.75
41536	ATTICOTOMY with reconstruction of the bony defect, with or without myringoplasty (Anaes.) (Assist.) Fee: \$1,039.20	Benefit: 75% = \$779.40	85% = \$982.10
41539	OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) Fee: \$883.70	Benefit: 75% = \$662.80	85% = \$826.60
41542	OSSICULAR CHAIN RECONSTRUCTION AND MYRINGOPLASTY (Anaes.) (Assist.) Fee: \$968.30	Benefit: 75% = \$726.25	85% = \$911.20
41545	MASTOIDECTOMY (CORTICAL) (Anaes.) (Assist.) Fee: \$422.60	Benefit: 75% = \$316.95	85% = \$365.50
41548	OBLITERATION OF THE MASTOID CAVITY (Anaes.) (Assist.) Fee: \$560.95	Benefit: 75% = \$420.75	85% = \$503.85
41551	MASTOIDECTOMY, intact wall technique, with myringoplasty (Anaes.) (Assist.) Fee: \$1,291.60	Benefit: 75% = \$968.70	85% = \$1,234.50
41554	MASTOIDECTOMY, intact wall technique, with myringoplasty and ossicular chain reconstruction (Anaes.) (Assist.) Fee: \$1,521.75	Benefit: 75% = \$1,141.35	85% = \$1,464.65

OPERATIONS		EAR, NOSE AND THROAT	
41557	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) (Anaes.) (Assist.) Fee: \$883.70 Benefit: 75% = \$662.80 85% = \$826.60		
41560	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL) AND MYRINGOPLASTY (Anaes.) Fee: \$968.30 Benefit: 75% = \$726.25 85% = \$911.20		
41563	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), MYRINGOPLASTY AND OSSICULAR CHAIN RECONSTRUCTION (Anaes.) (Assist.) Fee: \$1,198.70 Benefit: 75% = \$899.05 85% = \$1,141.60		
41564	MASTOIDECTOMY (RADICAL OR MODIFIED RADICAL), OBLITERATION OF THE MASTOID CAVITY, BLIND SAC CLOSURE OF EXTERNAL AUDITORY CANAL AND OBLITERATION OF EUSTACHIAN TUBE (Anaes.) (Assist.) Fee: \$1,550.10 Benefit: 75% = \$1,162.60 85% = \$1,493.00		
41566	REVISION OF MASTOIDECTOMY (radical, modified radical or intact wall), including myringoplasty (Anaes.) (Assist.) Fee: \$883.70 Benefit: 75% = \$662.80 85% = \$826.60		
41569	DECOMPRESSION OF FACIAL NERVE in its mastoid portion (Anaes.) (Assist.) Fee: \$968.30 Benefit: 75% = \$726.25 85% = \$911.20		
41572	LABYRINTHOTOMY OR DESTRUCTION OF LABYRINTH (Anaes.) (Assist.) Fee: \$837.60 Benefit: 75% = \$628.20 85% = \$780.50		
41575	CEREBELLO PONTINE ANGLE TUMOUR, removal of by 2 surgeons operating conjointly, by transmastoid, translabyrinthine or retromastoid approach transmastoid, translabyrinthine or retromastoid procedure (including aftercare) (Anaes.) (Assist.) Fee: \$1,974.85 Benefit: 75% = \$1,481.15 85% = \$1,917.75		
41576	CEREBELLO - PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach - intracranial procedure (including aftercare) not being a service to which item 41578 or 41579 applies (Anaes.) (Assist.) Fee: \$2,962.25 Benefit: 75% = \$2,221.70 85% = \$2,905.15		
41578	CEREBELLO PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$1,974.85 Benefit: 75% = \$1,481.15 85% = \$1,917.75		
41579	CEREBELLO-PONTINE ANGLE TUMOUR, removal of, by transmastoid, translabyrinthine or retromastoid approach, (intracranial procedure) - conjoint surgery, co-surgeon (Assist.) Fee: \$1,481.05 Benefit: 75% = \$1,110.80 85% = \$1,423.95		
41581	TUMOUR INVOLVING INFRA-TEMPORAL FOSSA, removal of, involving craniotomy and radical excision of (Anaes.) (Assist.) Fee: \$2,271.40 Benefit: 75% = \$1,703.55 85% = \$2,214.30		
41584	PARTIAL TEMPORAL BONE RESECTION for removal of tumour involving mastoidectomy with or without decompression of facial nerve (Anaes.) (Assist.) Fee: \$1,558.80 Benefit: 75% = \$1,169.10 85% = \$1,501.70		
41587	TOTAL TEMPORAL BONE RESECTION for removal of tumour (Anaes.) (Assist.) Fee: \$2,123.00 Benefit: 75% = \$1,592.25 85% = \$2,065.90		
41590	ENDOLYMPHATIC SAC, TRANSMASTOID DECOMPRESSION with or without drainage of (Anaes.) (Assist.) Fee: \$968.30 Benefit: 75% = \$726.25 85% = \$911.20		
41593	TRANSLABYRINTHINE VESTIBULAR NERVE SECTION (Anaes.) (Assist.) Fee: \$1,262.00 Benefit: 75% = \$946.50 85% = \$1,204.90		
41596	RETROLABYRINTHINE VESTIBULAR NERVE SECTION or COCHLEAR NERVE SECTION, or BOTH (Anaes.) (Assist.) Fee: \$1,410.40 Benefit: 75% = \$1,057.80 85% = \$1,353.30		
41599	INTERNAL AUDITORY MEATUS, exploration by middle cranial fossa approach with cranial nerve decompression (Anaes.) (Assist.) Fee: \$1,410.40 Benefit: 75% = \$1,057.80 85% = \$1,353.30		
41608	STAPEDECTOMY (Anaes.) (Assist.) Fee: \$883.70 Benefit: 75% = \$662.80 85% = \$826.60		

OPERATIONS		EAR, NOSE AND THROAT	
41611	STAPES MOBILISATION (Anaes.) (Assist.) Fee: \$568.55	Benefit: 75% = \$426.45	85% = \$511.45
41614	ROUND WINDOW SURGERY including repair of cochleotomy (Anaes.) (Assist.) Fee: \$883.70	Benefit: 75% = \$662.80	85% = \$826.60
41615	OVAL WINDOW SURGERY, including repair of fistula, not being a service associated with a service to which any other item in this Group applies (Anaes.) (Assist.) Fee: \$883.70	Benefit: 75% = \$662.80	85% = \$826.60
41617	COCHLEAR IMPLANT, insertion of, including mastoidectomy (Anaes.) (Assist.) Fee: \$1,536.60	Benefit: 75% = \$1,152.45	85% = \$1,479.50
41620	GLOMUS TUMOUR, transtympanic removal of (Anaes.) (Assist.) Fee: \$668.50	Benefit: 75% = \$501.40	85% = \$611.40
41623	GLOMUS TUMOUR, transmastoid removal of, including mastoidectomy (Anaes.) (Assist.) Fee: \$968.30	Benefit: 75% = \$726.25	85% = \$911.20
41626	ABSCESS OR INFLAMMATION OF MIDDLE EAR, operation for (excluding aftercare) (Anaes.) Fee: \$116.80	Benefit: 75% = \$87.60	85% = \$99.30
41629	MIDDLE EAR, EXPLORATION OF (Anaes.) (Assist.) Fee: \$422.60	Benefit: 75% = \$316.95	85% = \$365.50
41632	MIDDLE EAR, insertion of tube for DRAINAGE OF (including myringotomy) (Anaes.) Fee: \$193.65	Benefit: 75% = \$145.25	85% = \$164.65
41635	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty (Anaes.) (Assist.) Fee: \$927.85	Benefit: 75% = \$695.90	85% = \$870.75
41638	CLEARANCE OF MIDDLE EAR FOR GRANULOMA, CHOLESTEATOMA and POLYP, 1 or more, with or without myringoplasty with ossicular chain reconstruction (Anaes.) (Assist.) Fee: \$1,158.05	Benefit: 75% = \$868.55	85% = \$1,100.95
41641	PERFORATION OF TYMPANUM, cauterisation or diathermy of (Anaes.) Fee: \$38.50	Benefit: 75% = \$28.90	85% = \$32.75
41644	EXCISION OF RIM OF EARDRUM PERFORATION, not being a service associated with myringoplasty (Anaes.) Fee: \$115.75	Benefit: 75% = \$86.85	85% = \$98.40
41647	EAR TOILET requiring use of operating microscope and microinspection of tympanic membrane with or without general anaesthesia (Anaes.) Fee: \$89.10	Benefit: 75% = \$66.85	85% = \$75.75
41650	TYMPANIC MEMBRANE, microinspection of 1 or both ears under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$89.10	Benefit: 75% = \$66.85	85% = \$75.75
41653	EXAMINATION OF NASAL CAVITY or POSTNASAL SPACE, or NASAL CAVITY AND POSTNASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$58.35	Benefit: 75% = \$43.80	85% = \$49.60
41656	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) Fee: \$99.55	Benefit: 75% = \$74.70	85% = \$84.65
41659	NOSE, removal of FOREIGN BODY IN, other than by simple probing (Anaes.) Fee: \$62.95	Benefit: 75% = \$47.25	85% = \$53.55
41662	NASAL POLYP OR POLYPI (SIMPLE), removal of (See para T8.52 of explanatory notes to this Category) Fee: \$66.90	Benefit: 75% = \$50.20	85% = \$56.90

OPERATIONS		EAR, NOSE AND THROAT	
41665 G 41668 S	NASAL POLYP OR POLYPI (requiring admission to hospital), removal of (Anaes.) (See para T8.52 of explanatory notes to this Category) Fee: \$139.85 Benefit: 75% = \$104.90	85% = \$118.90	
	Fee: \$178.30 Benefit: 75% = \$133.75	85% = \$151.60	
41671	NASAL SEPTUM, SEPTOPLASTY, SUBMUCOUS RESECTION or closure of septal perforation (Anaes.) Fee: \$391.80 Benefit: 75% = \$293.85	85% = \$334.70	
41672	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) Fee: \$488.85 Benefit: 75% = \$366.65	85% = \$431.75	
41674	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES OR PHARYNX - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) Fee: \$81.45 Benefit: 75% = \$61.10	85% = \$69.25	
41677	NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) Fee: \$72.95 Benefit: 75% = \$54.75	85% = \$62.05	
41680	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) Fee: \$132.15 Benefit: 75% = \$99.15	85% = \$112.35	
41683	DIVISION OF NASAL ADHESIONS, with or without stenting not being a service associated with any other operation on the nose and not performed during the postoperative period of a nasal operation (Anaes.) Fee: \$94.95 Benefit: 75% = \$71.25	85% = \$80.75	
41686	DISLOCATION OF TURBINATE OR TURBINATES, 1 or both sides, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$58.35 Benefit: 75% = \$43.80	85% = \$49.60	
41689	TURBINECTOMY or turbinectomies, partial or total, unilateral (Anaes.) Fee: \$110.65 Benefit: 75% = \$83.00	85% = \$94.10	
41692	TURBINATES, submucous resection of, unilateral (Anaes.) Fee: \$144.35 Benefit: 75% = \$108.30	85% = \$122.70	
41695	TURBINATES, cryotherapy to (Anaes.) Fee: \$81.05 Benefit: 75% = \$60.80	85% = \$68.90	
41698	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) Fee: \$26.35 Benefit: 75% = \$19.80	85% = \$22.40	
41701	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$74.60 Benefit: 75% = \$55.95	85% = \$63.45	
41704	MAXILLARY ANTRUM, LAVAGE OF each attendance at which the procedure is performed, including any associated consultation (Anaes.) Fee: \$29.45 Benefit: 75% = \$22.10	85% = \$25.05	
41707	MAXILLARY ARTERY, transantral ligation of (Anaes.) (Assist.) Fee: \$363.65 Benefit: 75% = \$272.75	85% = \$309.15	
41710	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95	85% = \$365.50	
41713	ANTROSTOMY (RADICAL) with transantral ethmoidectomy or transantral vidian neurectomy (Anaes.) (Assist.) Fee: \$491.75 Benefit: 75% = \$368.85	85% = \$434.65	
41716	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85	85% = \$203.80	
41719	ANTRUM, drainage of, through tooth socket (Anaes.) Fee: \$95.25 Benefit: 75% = \$71.45	85% = \$81.00	
41722	OROANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35	85% = \$419.35	

OPERATIONS		EAR, NOSE AND THROAT
41725	ETHMOIDAL ARTERY OR ARTERIES, transorbital ligation of (unilateral) (Anaes.) (Assist.) Fee: \$363.65 Benefit: 75% = \$272.75 85% = \$309.15	
41728	LATERAL RHINOTOMY with removal of tumour (Anaes.) (Assist.) Fee: \$727.50 Benefit: 75% = \$545.65 85% = \$670.40	
41729	DERMOID OF NOSE, excision of, with intranasal extension (Anaes.) (Assist.) Fee: \$461.05 Benefit: 75% = \$345.80 85% = \$403.95	
41731	FRONTONASAL ETHMOIDECTOMY by external approach with or without sphenoidectomy (Anaes.) (Assist.) Fee: \$630.10 Benefit: 75% = \$472.60 85% = \$573.00	
41734	RADICAL FRONTOETHMOIDECTOMY with osteoplastic flap (Anaes.) (Assist.) Fee: \$822.20 Benefit: 75% = \$616.65 85% = \$765.10	
41737	FRONTAL SINUS, OR ETHMOIDAL SINUSES ON THE ONE SIDE, intranasal operation on (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70	
41740	FRONTAL SINUS, catheterisation of (Anaes.) Fee: \$47.65 Benefit: 75% = \$35.75 85% = \$40.55	
41743	FRONTAL SINUS, trephine of (Anaes.) (Assist.) Fee: \$273.55 Benefit: 75% = \$205.20 85% = \$232.55	
41746	FRONTAL SINUS, radical obliteration of (Anaes.) (Assist.) Fee: \$630.10 Benefit: 75% = \$472.60 85% = \$573.00	
41749	ETHMOIDAL SINUSES, external operation on (Anaes.) (Assist.) Fee: \$491.75 Benefit: 75% = \$368.85 85% = \$434.65	
41752	SPHENOIDAL SINUS, intranasal operation on (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
41755	EUSTACHIAN TUBE, catheterisation of (Anaes.) Fee: \$37.70 Benefit: 75% = \$28.30 85% = \$32.05	
41758	DIVISION OF PHARYNGEAL ADHESIONS (Anaes.) Fee: \$95.25 Benefit: 75% = \$71.45 85% = \$81.00	
41761	POSTNASAL SPACE, direct examination of, with or without biopsy (Anaes.) Fee: \$99.55 Benefit: 75% = \$74.70 85% = \$84.65	
41764	NASENOSCOPY or SINOSCOPY or FIBROPTIC EXAMINATION of NASOPHARYNX and LARYNX, one or more of these procedures (Anaes.) Fee: \$99.55 Benefit: 75% = \$74.70 85% = \$84.65	
41767	NASOPHARYNGEAL ANGIOFIBROMA, transpalatal removal (Anaes.) (Assist.) Fee: \$597.50 Benefit: 75% = \$448.15 85% = \$540.40	
41770	PHARYNGEAL POUCH, removal of, with or without cricopharyngeal myotomy (Anaes.) (Assist.) Fee: \$568.55 Benefit: 75% = \$426.45 85% = \$511.45	
41773	PHARYNGEAL POUCH, ENDOSCOPIC RESECTION OF (Dohlman's operation) (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35	
41776	CRICOPHARYNGEAL MYOTOMY with or without inversion of pharyngeal pouch (Anaes.) (Assist.) Fee: \$475.05 Benefit: 75% = \$356.30 85% = \$417.95	
41779	PHARYNGOTOMY (lateral), with or without total excision of tongue (Anaes.) (Assist.) Fee: \$568.55 Benefit: 75% = \$426.45 85% = \$511.45	
41782	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY (Anaes.) (Assist.) Fee: \$771.95 Benefit: 75% = \$579.00 85% = \$714.85	
41785	PARTIAL PHARYNGECTOMY via PHARYNGOTOMY with partial or total glossectomy (Anaes.) (Assist.) Fee: \$957.65 Benefit: 75% = \$718.25 85% = \$900.55	

OPERATIONS		EAR, NOSE AND THROAT	
41786	UVULOPALATOPHARYNGOPLASTY, with or without tonsillectomy, by any means (Anaes.) (Assist.) Fee: \$597.50 Benefit: 75% = \$448.15 85% = \$540.40		
41787	UVULECTOMY AND PARTIAL PALATECTOMY WITH LASER INCISION OF THE PALATE, with or without tonsillectomy, 1 or more stages, including any revision procedures within 12 months (Anaes.) (Assist.) Fee: \$461.05 Benefit: 75% = \$345.80 85% = \$403.95		
41788 G 41789 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person aged LESS THAN 12 YEARS (Anaes.) Fee: \$178.30 Benefit: 75% = \$133.75 85% = \$151.60 Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80		
41792 G 41793 S	TONSILS OR TONSILS AND ADENOIDS, removal of, in a person 12 YEARS OF AGE OR OVER (Anaes.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70 Fee: \$301.20 Benefit: 75% = \$225.90 85% = \$256.05		
41796 G 41797 S	TONSILS OR TONSILS AND ADENOIDS, ARREST OF HAEMORRHAGE requiring general anaesthesia, following removal of (Anaes.) Fee: \$92.20 Benefit: 75% = \$69.15 85% = \$78.40 Fee: \$116.80 Benefit: 75% = \$87.60 85% = \$99.30		
41800 G 41801 S	ADENOIDS, removal of (Anaes.) Fee: \$95.25 Benefit: 75% = \$71.45 85% = \$81.00 Fee: \$132.15 Benefit: 75% = \$99.15 85% = \$112.35		
41804	LINGUAL TONSIL OR LATERAL PHARYNGEAL BANDS, removal of (Anaes.) Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05		
41807	PERITONSILLAR ABSCESS (quinsy), incision of (Anaes.) Fee: \$56.90 Benefit: 75% = \$42.70 85% = \$48.40		
41810	UVULOTOMY or UVULECTOMY (Anaes.) Fee: \$28.90 Benefit: 75% = \$21.70 85% = \$24.60		
41813	VALLECULAR OR PHARYNGEAL CYSTS, removal of (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65		
41816	OESOPHAGOSCOPY (with rigid oesophagoscope) (Anaes.) Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00		
41819	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope (Anaes.) Fee: \$282.95 Benefit: 75% = \$212.25 85% = \$240.55		
41820	DILATATION OF STRICTURE OF UPPER GASTRO-INTESTINAL TRACT using bougie or balloon over endoscopically inserted guidewire, including endoscopy with flexible or rigid endoscope, where the use of imaging intensification is clinically indicated (Anaes.) Fee: \$339.55 Benefit: 75% = \$254.70 85% = \$288.65		
41822	OESOPHAGOSCOPY (with rigid oesophagoscope), with biopsy (Anaes.) Fee: \$193.65 Benefit: 75% = \$145.25 85% = \$164.65		
41825	OESOPHAGOSCOPY (with rigid oesophagoscope), with removal of foreign body (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65		
41828	OESOPHAGEAL STRICTURE, dilatation of, without oesophagoscopy (Anaes.) Fee: \$42.35 Benefit: 75% = \$31.80 85% = \$36.00		
41831	OESOPHAGUS, endoscopic pneumatic dilatation of (Anaes.) (Assist.) Fee: \$289.45 Benefit: 75% = \$217.10 85% = \$246.05		
41832	OESOPHAGUS, balloon dilatation of, using interventional imaging techniques (Anaes.) Fee: \$185.20 Benefit: 75% = \$138.90 85% = \$157.45		
41834	LARYNGECTOMY (TOTAL) (Anaes.) (Assist.) Fee: \$1,045.10 Benefit: 75% = \$783.85 85% = \$988.00		

OPERATIONS		EAR, NOSE AND THROAT
41837	VERTICAL HEMILARYNGECTOMY including tracheostomy (Anaes.) (Assist.) Fee: \$1,002.15 Benefit: 75% = \$751.65 85% = \$945.05	
41840	SUPRAGLOTTIC LARYNGECTOMY including tracheostomy (Anaes.) (Assist.) Fee: \$1,232.25 Benefit: 75% = \$924.20 85% = \$1,175.15	
41843	LARYNGOPHARYNGECTOMY or PRIMARY RESTORATION OF ALIMENTARY CONTINUITY after laryngopharyngectomy USING STOMACH OR BOWEL (Anaes.) (Assist.) Fee: \$1,083.55 Benefit: 75% = \$812.70 85% = \$1,026.45	
41846	LARYNX, direct examination of the supraglottic, glottic and subglottic regions, not being a service associated with any other procedure on the larynx or with the administration of a general anaesthetic (Anaes.) <i>(See para T8.53 of explanatory notes to this Category)</i> Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00	
41849	LARYNX, direct examination of, with biopsy (Anaes.) (Assist.) Fee: \$221.25 Benefit: 75% = \$165.95 85% = \$188.10	
41852	LARYNX, direct examination of, WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
41855	MICROLARYNGOSCOPY (Anaes.) (Assist.) Fee: \$233.65 Benefit: 75% = \$175.25 85% = \$198.65	
41858	MICROLARYNGOSCOPY with removal of juvenile papillomata (Anaes.) (Assist.) <i>(See para T8.54 of explanatory notes to this Category)</i> Fee: \$400.70 Benefit: 75% = \$300.55 85% = \$343.60	
41861	MICROLARYNGOSCOPY with removal of papillomata by laser surgery (Anaes.) (Assist.) Fee: \$489.90 Benefit: 75% = \$367.45 85% = \$432.80	
41864	MICROLARYNGOSCOPY WITH REMOVAL OF TUMOUR (Anaes.) (Assist.) Fee: \$330.45 Benefit: 75% = \$247.85 85% = \$280.90	
41867	MICROLARYNGOSCOPY with arytenoidectomy (Anaes.) (Assist.) Fee: \$497.30 Benefit: 75% = \$373.00 85% = \$440.20	
41868	LARYNGEAL WEB, division of, using microlaryngoscopic techniques (Anaes.) Fee: \$315.15 Benefit: 75% = \$236.40 85% = \$267.90	
41869	BOTULINUM TOXIN INJECTION INTO VOCAL CORDS, including associated consultation Fee: \$216.50 Benefit: 75% = \$162.40 85% = \$184.05	
41870	INJECTION OF VOCAL CORD BY TEFLON, FAT, COLLAGEN OR GELFOAM (Anaes.) (Assist.) Fee: \$368.80 Benefit: 75% = \$276.60 85% = \$313.50	
41873	LARYNX, FRACTURED, operation for (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35	
41876	LARYNX, external operation on, OR LARYNGOFISSURE with or without cordectomy (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35	
41879	LARYNGOPLASTY or TRACHEOPLASTY, including tracheostomy (Anaes.) (Assist.) Fee: \$771.95 Benefit: 75% = \$579.00 85% = \$714.85	
41880	TRACHEOSTOMY by a percutaneous technique using sequential dilatation or partial splitting method to allow insertion of a cuffed tracheostomy tube (Anaes.) Fee: \$206.05 Benefit: 75% = \$154.55 85% = \$175.15	
41881	TRACHEOSTOMY by open exposure of the trachea, including separation of the strap muscles or division of the thyroid isthmus, where performed (Anaes.) (Assist.) Fee: \$325.70 Benefit: 75% = \$244.30 85% = \$276.85	
41884	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrach or similar device (Anaes.) Fee: \$73.80 Benefit: 75% = \$55.35 85% = \$62.75	

OPERATIONS		OPHTHALMOLOGY	
41885	TRACHE-OESOPHAGEAL FISTULA, formation of, as a secondary procedure following laryngectomy, including associated endoscopic procedures (Anaes.) (Assist.) Fee: \$233.40 Benefit: 75% = \$175.05 85% = \$198.40		
41886	TRACHEA, removal of foreign body in (Anaes.) (Assist.) Fee: \$144.35 Benefit: 75% = \$108.30 85% = \$122.70		
41889	BRONCHOSCOPY, as an independent procedure (Anaes.) Fee: \$144.35 Benefit: 75% = \$108.30 85% = \$122.70		
41892	BRONCHOSCOPY with 1 or more endobronchial biopsies or other diagnostic or therapeutic procedures (Anaes.) Fee: \$190.60 Benefit: 75% = \$142.95 85% = \$162.05		
41895	BRONCHUS, removal of foreign body in (Anaes.) (Assist.) Fee: \$298.15 Benefit: 75% = \$223.65 85% = \$253.45		
41898	FIBROPTIC BRONCHOSCOPY with 1 or more transbronchial lung biopsies, with or without bronchial or bronchoalveolar lavage, with or without the use of interventional imaging (Anaes.) (Assist.) Fee: \$208.35 Benefit: 75% = \$156.30 85% = \$177.10		
41901	ENDOSCOPIC LASER RESECTION OF ENDOBRONCHIAL TUMOURS for relief of obstruction including any associated endoscopic procedures (Anaes.) (Assist.) Fee: \$489.90 Benefit: 75% = \$367.45 85% = \$432.80		
41904	BRONCHOSCOPY with dilatation of tracheal stricture (Anaes.) Fee: \$199.80 Benefit: 75% = \$149.85 85% = \$169.85		
41905	TRACHEA OR BRONCHUS, dilatation of stricture and endoscopic insertion of stent (Anaes.) (Assist.) Fee: \$367.60 Benefit: 75% = \$275.70 85% = \$312.50		
41907	NASAL SEPTUM BUTTON, insertion of (Anaes.) Fee: \$99.55 Benefit: 75% = \$74.70 85% = \$84.65		
41910	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) Fee: \$316.40 Benefit: 75% = \$237.30 85% = \$268.95		
SUBGROUP 9 - OPHTHALMOLOGY			
42503	OPHTHALMOLOGICAL EXAMINATION under general anaesthesia, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$83.05 Benefit: 75% = \$62.30 85% = \$70.60		
42506	EYE, ENUCLEATION OF, with or without sphere implant (Anaes.) (Assist.) Fee: \$390.20 Benefit: 75% = \$292.65 85% = \$333.10		
42509	EYE, ENUCLEATION OF, with insertion of integrated implant (Anaes.) (Assist.) Fee: \$493.80 Benefit: 75% = \$370.35 85% = \$436.70		
42510	EYE, enucleation of, with insertion of hydroxy apatite implant or similar coralline implant (Anaes.) (Assist.) Fee: \$569.20 Benefit: 75% = \$426.90 85% = \$512.10		
42512	GLOBE, EVISCERATION OF (Anaes.) (Assist.) Fee: \$390.20 Benefit: 75% = \$292.65 85% = \$333.10		
42515	GLOBE, EVISCERATION OF, AND INSERTION OF INTRASCLERAL BALL OR CARTILAGE (Anaes.) (Assist.) Fee: \$493.80 Benefit: 75% = \$370.35 85% = \$436.70		
42518	ANOPHTHALMIC ORBIT, INSERTION OF CARTILAGE OR ARTIFICIAL IMPLANT as a delayed procedure, or REMOVAL OF IMPLANT FROM SOCKET, or PLACEMENT OF A MOTILITY INTEGRATING PEG by drilling into an existing orbital implant (Anaes.) (Assist.) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42521	ANOPHTHALMIC SOCKET, treatment of, by insertion of a wired-in conformer, integrated implant or dermofat graft, as a secondary procedure (Anaes.) (Assist.) Fee: \$975.55 Benefit: 75% = \$731.70 85% = \$918.45		

OPERATIONS		OPHTHALMOLOGY	
42524	ORBIT, SKIN GRAFT TO, as a delayed procedure (Anaes.) Fee: \$165.90 Benefit: 75% = \$124.45 85% = \$141.05		
42527	CONTRACTED SOCKET, RECONSTRUCTION INCLUDING MUCOUS MEMBRANE GRAFTING AND STENT MOULD (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80		
42530	ORBIT, EXPLORATION with or without biopsy, requiring REMOVAL OF BONE (Anaes.) (Assist.) Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
42533	ORBIT, EXPLORATION OF, with drainage or biopsy not requiring removal of bone (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80		
42536	ORBIT, EXENTERATION OF, with or without skin graft and with or without temporalis muscle transplant (Anaes.) (Assist.) Fee: \$676.75 Benefit: 75% = \$507.60 85% = \$619.65		
42539	ORBIT, EXPLORATION OF, with removal of tumour or foreign body, requiring removal of bone (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25		
42542	ORBIT, exploration of anterior aspect with removal of tumour or foreign body (Anaes.) (Assist.) Fee: \$408.55 Benefit: 75% = \$306.45 85% = \$351.45		
42543	ORBIT, exploration of retrobulbar aspect with removal of tumour or foreign body (Anaes.) (Assist.) Fee: \$716.60 Benefit: 75% = \$537.45 85% = \$659.50		
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.) (Assist.) Fee: \$1,036.45 Benefit: 75% = \$777.35 85% = \$979.35		
42548	OPTIC NERVE MENINGES, incision of (Anaes.) (Assist.) Fee: \$615.75 Benefit: 75% = \$461.85 85% = \$558.65		
42551	EYEBALL, PERFORATING WOUND OF, not involving intraocular structures repair involving suture of cornea or sclera, or both, not being a service to which item 42632 applies (Anaes.) (Assist.) Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
42554	EYEBALL, PERFORATING WOUND OF, with incarceration or prolapse of uveal tissue repair (Anaes.) (Assist.) Fee: \$597.50 Benefit: 75% = \$448.15 85% = \$540.40		
42557	EYEBALL, PERFORATING WOUND OF, with incarceration of lens or vitreous repair (Anaes.) (Assist.) Fee: \$835.20 Benefit: 75% = \$626.40 85% = \$778.10		
42560	INTRAOCULAR FOREIGN BODY, magnetic removal from anterior segment (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80		
42563	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from anterior segment (Anaes.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60		
42566	INTRAOCULAR FOREIGN BODY, magnetic removal from posterior segment (Anaes.) (Assist.) Fee: \$597.50 Benefit: 75% = \$448.15 85% = \$540.40		
42569	INTRAOCULAR FOREIGN BODY, nonmagnetic removal from posterior segment (Anaes.) (Assist.) Fee: \$835.20 Benefit: 75% = \$626.40 85% = \$778.10		
42572	ORBITAL ABSCESS OR CYST, drainage of (Anaes.) Fee: \$95.05 Benefit: 75% = \$71.30 85% = \$80.80		
42573	DERMOID, periorbital, excision of (Anaes.) Fee: \$184.45 Benefit: 75% = \$138.35 85% = \$156.80		
42574	DERMOID, orbital, excision of (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70		
42575	TARSAL CYST, extirpation of (Anaes.) Fee: \$67.10 Benefit: 75% = \$50.35 85% = \$57.05		

OPERATIONS		OPHTHALMOLOGY	
42578	TARSAL CARTILAGE, excision of (Anaes.) (Assist.) Fee: \$377.90 Benefit: 75% = \$283.45 85% = \$321.25		
42581	ECTROPION OR ENTROPION, tarsal cauterisation of (Anaes.) Fee: \$95.05 Benefit: 75% = \$71.30 85% = \$80.80		
42584	TARSORRHAPHY (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70		
42587	TRICHIASIS, treatment of by cryotherapy, laser or electrolysis - each eyelid (Anaes.) Fee: \$42.10 Benefit: 75% = \$31.60 85% = \$35.80		
42590	CANTHOPLASTY, medial or lateral (Anaes.) (Assist.) Fee: \$274.30 Benefit: 75% = \$205.75 85% = \$233.20		
42593	LACRIMAL GLAND, excision of palpebral lobe (Anaes.) Fee: \$165.90 Benefit: 75% = \$124.45 85% = \$141.05		
42596	LACRIMAL SAC, excision of, or operation on (Anaes.) (Assist.) Fee: \$408.55 Benefit: 75% = \$306.45 85% = \$351.45		
42599	LACRIMAL CANALICULAR SYSTEM, establishment of patency by closed operation using silicone tubes or similar, 1 eye (Anaes.) (Assist.) Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
42602	LACRIMAL CANALICULAR SYSTEM, establishment of patency by open operation, 1 eye (Anaes.) (Assist.) Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
42605	LACRIMAL CANALICULUS, immediate repair of (Anaes.) (Assist.) Fee: \$377.90 Benefit: 75% = \$283.45 85% = \$321.25		
42608	LACRIMAL DRAINAGE by insertion of glass tube, as an independent procedure (Anaes.) (Assist.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30		
42610	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, unilateral, with or without lavage - under general anaesthesia (Anaes.) Fee: \$78.00 Benefit: 75% = \$58.50 85% = \$66.30		
42611	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing for obstruction, bilateral, with or without lavage - under general anaesthesia (Anaes.) Fee: \$117.05 Benefit: 75% = \$87.80 85% = \$99.50		
42614	NASOLACRIMAL TUBE (unilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, unilateral, including lavage, not being a service associated with a service to which item 42610 applies (excluding aftercare) Fee: \$39.10 Benefit: 75% = \$29.35 85% = \$33.25		
42615	NASOLACRIMAL TUBE (bilateral), removal or replacement of, or LACRIMAL PASSAGES, probing to establish patency of the lacrimal passage and/or site of obstruction, bilateral, including lavage, not being a service associated with a service to which item 42611 applies (excluding aftercare) Fee: \$58.55 Benefit: 75% = \$43.95 85% = \$49.80		
42617	PUNCTUM SNIP operation (Anaes.) Fee: \$111.00 Benefit: 75% = \$83.25 85% = \$94.35		
42620	PUNCTUM, occlusion of, by use of a plug (Anaes.) Fee: \$42.75 Benefit: 75% = \$32.10 85% = \$36.35		
42621	PUNCTUM, temporary occlusion of, by use of electrical cautery (Anaes.) Fee: \$42.75 Benefit: 75% = \$32.10 85% = \$36.35		
42622	PUNCTUM, permanent occlusion of, by use of electrical cautery (Anaes.) Fee: \$67.10 Benefit: 75% = \$50.35 85% = \$57.05		
42623	DACRYOCYSTORHINOSTOMY (Anaes.) (Assist.) Fee: \$567.10 Benefit: 75% = \$425.35 85% = \$510.00		

OPERATIONS		OPHTHALMOLOGY
42626	DACRYOCYSTORHINOSTOMY where a previous dacryocystorhinostomy has been performed (Anaes.) (Assist.) Fee: \$914.55 Benefit: 75% = \$685.95 85% = \$857.45	
42629	CONJUNCTIVORHINOSTOMY including dacryocystorhinostomy and fashioning of conjunctival flaps (Anaes.) (Assist.) Fee: \$688.95 Benefit: 75% = \$516.75 85% = \$631.85	
42632	CONJUNCTIVAL PERITOMY OR REPAIR OF CORNEAL LACERATION by conjunctival flap (Anaes.) Fee: \$95.05 Benefit: 75% = \$71.30 85% = \$80.80	
42635	CORNEAL PERFORATIONS, sealing of, with tissue adhesive (Anaes.) (Assist.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30	
42638	CONJUNCTIVAL GRAFT OVER CORNEA (Anaes.) (Assist.) Fee: \$304.85 Benefit: 75% = \$228.65 85% = \$259.15	
42641	AUTOCONJUNCTIVAL TRANSPLANT, or mucous membrane graft (Anaes.) (Assist.) Fee: \$396.25 Benefit: 75% = \$297.20 85% = \$339.15	
42644	CORNEA OR SCLERA, removal of imbedded foreign body from (excluding aftercare) (Anaes.) Fee: \$58.50 Benefit: 75% = \$43.90 85% = \$49.75	
42647	CORNEAL SCARS, removal of, by partial keratectomy, not being a service associated with a service to which item 42686 applies (Anaes.) Fee: \$165.90 Benefit: 75% = \$124.45 85% = \$141.05	
42650	CORNEA, epithelial debridement for corneal ulcer or corneal erosion (excluding aftercare) (Anaes.) Fee: \$58.50 Benefit: 75% = \$43.90 85% = \$49.75	
42651	CORNEA, epithelial debridement for eliminating band keratopathy (Anaes.) Fee: \$130.35 Benefit: 75% = \$97.80 85% = \$110.80	
42653	CORNEA, transplantation of, full thickness (Anaes.) (Assist.) Fee: \$1,085.20 Benefit: 75% = \$813.90 85% = \$1,028.10	
42656	CORNEA, transplantation of, where there have been 2 previous graft operations (Anaes.) (Assist.) Fee: \$1,353.50 Benefit: 75% = \$1,015.15 85% = \$1,296.40	
42659	CORNEA, transplantation of, superficial or lamellar (Anaes.) (Assist.) Fee: \$731.60 Benefit: 75% = \$548.70 85% = \$674.50	
42662	SCLERA, transplantation of, full thickness, including collection of donor material (Anaes.) (Assist.) Fee: \$731.60 Benefit: 75% = \$548.70 85% = \$674.50	
42665	SCLERA, transplantation of, superficial or lamellar, including collection of donor material (Anaes.) (Assist.) Fee: \$487.75 Benefit: 75% = \$365.85 85% = \$430.65	
42667	RUNNING CORNEAL SUTURE, manipulation of, performed within 4 months of corneal grafting, to reduce astigmatism where a reduction of 2 dioptres of astigmatism is obtained, including any associated consultation Fee: \$115.05 Benefit: 75% = \$86.30 85% = \$97.80	
42668	CORNEAL SUTURES, removal of, not earlier than 6 weeks after operation requiring use of slit lamp or operating microscope (Anaes.) Fee: \$61.05 Benefit: 75% = \$45.80 85% = \$51.90	
42671	REFRACTIVE KERATOPLASTY with penetrating incisions (excluding radial keratotomy) following corneal grafting or intraocular operation INCLUDING ANY MEASUREMENTS AND CALCULATIONS associated with the procedure (Anaes.) (Assist.) <i>(See para T8.55 of explanatory notes to this Category)</i> Fee: \$731.60 Benefit: 75% = \$548.70 85% = \$674.50	
42674	CORNEAL INCISIONS, non penetrating, for the correction of astigmatism following surgery of anterior chamber or corneal grafting, and including associated ultrasound pachymetry of corneal thickness, with or without compression sutures (Anaes.) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95	
42676	CONJUNCTIVA, biopsy of, as an independent procedure Fee: \$93.85 Benefit: 75% = \$70.40 85% = \$79.80	

OPERATIONS		OPHTHALMOLOGY	
42677	CONJUNCTIVA, CAUTERY OF, INCLUDING TREATMENT OF PANNUS each attendance at which treatment is given including any associated consultation (Anaes.) Fee: \$49.40 Benefit: 75% = \$37.05 85% = \$42.00		
42680	CONJUNCTIVA, cryotherapy to, for melanotic lesions or similar using CO ² or N ² O (Anaes.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30		
42683	CONJUNCTIVAL CYSTS, removal of, requiring admission to hospital or approved day-hospital facility (Anaes.) Fee: \$97.55 Benefit: 75% = \$73.20 85% = \$82.95		
42686	PTERYGIUM, removal of (Anaes.) Fee: \$221.90 Benefit: 75% = \$166.45 85% = \$188.65		
42689	PINGUECULA, removal of, not being a service associated with the fitting of contact lenses (Anaes.) Fee: \$95.05 Benefit: 75% = \$71.30 85% = \$80.80		
42692	LIMBIC TUMOUR, removal of, excluding Pterygium (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70		
42695	LIMBIC TUMOUR, excision of, requiring keratectomy or sclerectomy, excluding Pterygium (Anaes.) (Assist.) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95		
42698	LENS EXTRACTION, excluding surgery performed for the correction of refractive error <i>except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye</i> (Anaes.) Fee: \$570.65 Benefit: 75% = \$428.00 85% = \$513.55		
42701	ARTIFICIAL LENS, insertion of, excluding surgery performed for the correction of refractive error <i>except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye</i> (Anaes.) Fee: \$318.20 Benefit: 75% = \$238.65 85% = \$270.50		
42702	LENS EXTRACTION AND INSERTION OF ARTIFICIAL LENS, excluding surgery performed for the correction of refractive error <i>except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye</i> (Anaes.) Fee: \$729.80 Benefit: 75% = \$547.35 85% = \$672.70		
42703	ARTIFICIAL LENS, insertion of, into the posterior chamber and suture to the iris and sclera (Anaes.) (Assist.) Fee: \$463.80 Benefit: 75% = \$347.85 85% = \$406.70		
42704	ARTIFICIAL LENS, REMOVAL or REPOSITIONING of by open operation, not being a service associated with a service to which item 42701 applies (Anaes.) Fee: \$377.90 Benefit: 75% = \$283.45 85% = \$321.25		
42707	ARTIFICIAL LENS, REMOVAL of and REPLACEMENT with a different lens (Anaes.) Fee: \$646.25 Benefit: 75% = \$484.70 85% = \$589.15		
42710	ARTIFICIAL LENS, removal of, and replacement with a lens inserted into the posterior chamber and sutured to the iris or sclera (Anaes.) (Assist.) Fee: \$731.60 Benefit: 75% = \$548.70 85% = \$674.50		
42713	INTRAOCULAR LENSES, repositioning of, by the use of a McCannell suture or similar (Anaes.) (Assist.) Fee: \$304.85 Benefit: 75% = \$228.65 85% = \$259.15		
42716	CATARACT, JUVENILE, removal of, including subsequent needlings (Anaes.) (Assist.) Fee: \$969.40 Benefit: 75% = \$727.05 85% = \$912.30		
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.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60		
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.) (Assist.) Fee: \$460.25 Benefit: 75% = \$345.20 85% = \$403.15		
42725	VITRECTOMY by posterior chamber sclerotomy including the removal of vitreous, division of bands or removal of preretinal membranes by cutting and suction and replacement by saline, Hartmann's or similar solution (Anaes.) (Assist.) Fee: \$1,085.20 Benefit: 75% = \$813.90 85% = \$1,028.10		

OPERATIONS		OPHTHALMOLOGY
42728	CRYOTHERAPY OF RETINA or other intraocular structures with an internal probe, being a service associated with a service to which item 42725 applies (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$155.55	
42731	CAPSULECTOMY or LENSECTOMY by posterior chamber sclerotomy in conjunction with the removal of vitreous or division of vitreous bands or removal of preretinal membrane from the posterior chamber by cutting and suction and replacement by saline, Hartmann's or similar solution, not being a service associated with any other intraocular operation (Anaes.) (Assist.) <i>(See para T8.56 of explanatory notes to this Category)</i> Fee: \$1,231.50 Benefit: 75% = \$923.65 85% = \$1,174.40	
42734	CAPSULOTOMY, other than by laser (Anaes.) (Assist.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30	
42737	NEEDLING OF POSTERIOR CAPSULE (Anaes.) (Assist.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30	
42740	PARACENTESIS OF ANTERIOR OR POSTERIOR CHAMBER OR BOTH, for the injection of therapeutic substances, or the removal of aqueous or vitreous for diagnostic purposes, 1 or more of (Anaes.) (Assist.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30	
42743	ANTERIOR CHAMBER, IRRIGATION OF BLOOD FROM, as an independent procedure (Anaes.) (Assist.) Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10	
42746	GLAUCOMA, filtering operation for (Anaes.) (Assist.) Fee: \$774.30 Benefit: 75% = \$580.75 85% = \$717.20	
42749	GLAUCOMA, filtering operation for, where previous filtering operation has been performed (Anaes.) (Assist.) Fee: \$969.40 Benefit: 75% = \$727.05 85% = \$912.30	
42752	GLAUCOMA, insertion of Molteno valve for, 1 or more stages (Anaes.) (Assist.) Fee: \$1,085.20 Benefit: 75% = \$813.90 85% = \$1,028.10	
42755	GLAUCOMA, removal of Molteno valve (Anaes.) Fee: \$134.15 Benefit: 75% = \$100.65 85% = \$114.05	
42758	GONIOTOMY (Anaes.) (Assist.) Fee: \$567.10 Benefit: 75% = \$425.35 85% = \$510.00	
42761	DIVISION OF ANTERIOR OR POSTERIOR SYNECHIAE, as an independent procedure, other than by laser (Anaes.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60	
42764	IRIDECTOMY (including excision of tumour of iris) OR IRIDOTOMY, as an independent procedure, other than by laser (Anaes.) (Assist.) Fee: \$420.70 Benefit: 75% = \$315.55 85% = \$363.60	
42767	TUMOUR, INVOLVING CILIARY BODY OR CILIARY BODY AND IRIS, excision of (Anaes.) (Assist.) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90	
42770	CYCLODESTRUCTIVE procedures for the treatment of intractable glaucoma, treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) <i>(See para T8.57 of explanatory notes to this Category)</i> Fee: \$239.05 Benefit: 75% = \$179.30 85% = \$203.20	
42771	CYCLODESTRUCTIVE PROCEDURES for the treatment of intractable glaucoma, treatment to one eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which 42770 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) <i>(See para T8.57 of explanatory notes to this Category)</i> Fee: \$235.30 Benefit: 75% = \$176.50 85% = \$200.05	
42773	DETACHED RETINA, diathermy or cryotherapy for, not being a service associated with a service to which item 42776 applies (Anaes.) (Assist.) Fee: \$731.60 Benefit: 75% = \$548.70 85% = \$674.50	
42776	DETACHED RETINA, buckling or resection operation for (Anaes.) (Assist.) Fee: \$1,085.20 Benefit: 75% = \$813.90 85% = \$1,028.10	

OPERATIONS		OPHTHALMOLOGY	
42779	DETACHED RETINA, revision operation for (Anaes.) (Assist.) Fee: \$1,353.50 Benefit: 75% = \$1,015.15 85% = \$1,296.40		
42782	LASER TRABECULOPLASTY - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para T8.58 of explanatory notes to this Category) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95		
42783	LASER TRABECULOPLASTY - each treatment to 1 eye - <i>where it can be demonstrated that a 5th or subsequent treatment to that eye (including any treatments to which item 42782 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) (See para T8.58 of explanatory notes to this Category) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95		
42785	LASER IRIDOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para T8.59 of explanatory notes to this Category) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42786	LASER IRIDOTOMY - each treatment to 1 eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42785 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) (See para T8.59 of explanatory notes to this Category) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42788	LASER CAPSULOTOMY - each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para T8.60 of explanatory notes to this Category) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42789	LASER CAPSULOTOMY - each treatment to 1 eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42788 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) (See para T8.60 of explanatory notes to this Category) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42791	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS -each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (Assist.) (See para T8.61 of explanatory notes to this Category) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42792	LASER VITREOLYSIS OR CORTICOLYSIS OF LENS MATERIAL OR FIBRINOLYSIS - each treatment to 1 eye - <i>where it can be demonstrated that a 3rd or subsequent treatment to that eye (including any treatments to which item 42791 applies) is indicated in a 2 year period</i> (Anaes.) (Assist.) (See para T8.61 of explanatory notes to this Category) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42794	DIVISION OF SUTURE BY LASER following trabeculoplasty, each treatment to 1 eye, to a maximum of 2 treatments to that eye in a 2 year period (Anaes.) (See para T8.62 of explanatory notes to this Category) Fee: \$54.85 Benefit: 75% = \$41.15 85% = \$46.65		
42797	LASER COAGULATION OF CORNEAL OR SCLERAL BLOOD VESSELS - each treatment to 1 eye, to a maximum of 4 treatments to that eye in a 2 year period (Anaes.) (See para T8.63 of explanatory notes to this Category) Fee: \$54.85 Benefit: 75% = \$41.15 85% = \$46.65		
42806	IRIS TUMOUR, laser photocoagulation of (Anaes.) (Assist.) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60		
42807	PHOTOMYDRIASIS, laser Fee: \$288.50 Benefit: 75% = \$216.40 85% = \$245.25		
42808	PHOTOIRIDOSYNERESIS, laser Fee: \$288.50 Benefit: 75% = \$216.40 85% = \$245.25		
42809	RETINA, photocoagulation of, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95		

OPERATIONS		OPHTHALMOLOGY	
42810	PHOTOTHERAPEUTIC KERATECTOMY, by laser, for corneal scarring or disease, excluding surgery for refractive error (Anaes.) Fee: \$460.30	Benefit: 75% = \$345.25	85% = \$403.20
42812	DETACHED RETINA, removal of encircling silicone band from (Anaes.) Fee: \$134.15	Benefit: 75% = \$100.65	85% = \$114.05
42815	POSTERIOR CHAMBER, removal of silicone oil from (Anaes.) (Assist.) Fee: \$512.20	Benefit: 75% = \$384.15	85% = \$455.10
42818	RETINA, CRYOTHERAPY TO, as an independent procedure, with external probe (Anaes.) Fee: \$475.45	Benefit: 75% = \$356.60	85% = \$418.35
42821	RETROBULBAR TRANSILLUMINATION, as an independent procedure (Anaes.) Fee: \$73.15	Benefit: 75% = \$54.90	85% = \$62.20
42824	RETROBULBAR INJECTION OF ALCOHOL OR OTHER DRUG, as an independent procedure Fee: \$56.70	Benefit: 75% = \$42.55	85% = \$48.20
42827	BOTULINUS TOXIN, injection of, for blepharospasm, including all such injections on any 1 day (Anaes.) Fee: \$36.55	Benefit: 75% = \$27.45	85% = \$31.10
42830	BOTULINUS TOXIN, injection of, for strabismus including all such injections on any 1 day and associated electromyography (Anaes.) Fee: \$126.85	Benefit: 75% = \$95.15	85% = \$107.85
42833	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES (Anaes.) (Assist.) Fee: \$475.45	Benefit: 75% = \$356.60	85% = \$418.35
42836	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 1 OR 2 MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (Anaes.) (Assist.) Fee: \$591.35	Benefit: 75% = \$443.55	85% = \$534.25
42839	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES (Anaes.) (Assist.) Fee: \$567.10	Benefit: 75% = \$425.35	85% = \$510.00
42842	SQUINT, OPERATION FOR, ON 1 OR BOTH EYES, the operation involving a total of 3 OR MORE MUSCLES where there have been 2 or more previous squint operations on the eye or eyes (Anaes.) (Assist.) Fee: \$707.25	Benefit: 75% = \$530.45	85% = \$650.15
42845	READJUSTMENT OF ADJUSTABLE SUTURES, 1 or both eyes, as an independent procedure following an operation for correction of squint (Anaes.) (See para T8.64 of explanatory notes to this Category) Fee: \$153.55	Benefit: 75% = \$115.20	85% = \$130.55
42848	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) (Anaes.) (Assist.) Fee: \$567.10	Benefit: 75% = \$425.35	85% = \$510.00
42851	SQUINT, muscle transplant for (Hummelsheim type, or similar operation) where there have been 2 or more previous squint operations on the eye or eyes (Anaes.) (Assist.) Fee: \$707.25	Benefit: 75% = \$530.45	85% = \$650.15
42854	RUPTURED MEDIAL PALPEBRAL LIGAMENT or ruptured EXTRAOCULAR MUSCLE, repair of (Anaes.) (Assist.) Fee: \$329.15	Benefit: 75% = \$246.90	85% = \$279.80
42857	RESUTURING OF WOUND FOLLOWING INTRAOCULAR PROCEDURES with or without excision of prolapsed iris (Anaes.) (Assist.) Fee: \$329.15	Benefit: 75% = \$246.90	85% = \$279.80
42860	EYELID (upper or lower), scleral or Goretex or other non-autogenous graft to, with recession of the lid retractors (Anaes.) (Assist.) Fee: \$731.60	Benefit: 75% = \$548.70	85% = \$674.50
42863	EYELID, recession of (Anaes.) (Assist.) Fee: \$627.95	Benefit: 75% = \$471.00	85% = \$570.85

OPERATIONS		OSTEOMYELITIS
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.) (Assist.) Fee: \$609.65 Benefit: 75% = \$457.25 85% = \$552.55	
42869	EYELID closure in facial nerve paralysis, insertion of foreign implant for (Anaes.) (Assist.) Fee: \$445.10 Benefit: 75% = \$333.85 85% = \$388.00	
42872	EYEBROW, elevation of, for parietic states (Anaes.) Fee: \$195.10 Benefit: 75% = \$146.35 85% = \$165.85	
SUBGROUP 10 - OPERATIONS FOR OSTEOMYELITIS		
OPERATIONS FOR ACUTE OSTEOMYELITIS		
43500	OPERATION ON PHALANX (Anaes.) Fee: \$100.05 Benefit: 75% = \$75.05 85% = \$85.05	
43503	OPERATION ON STERNUM, CLAVICLE, RIB, ULNA, RADIUS, CARPUS, TIBIA, FIBULA, TARSUS, SKULL, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE (Anaes.) Fee: \$166.00 Benefit: 75% = \$124.50 85% = \$141.10	
43506	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
43509	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
OPERATIONS FOR CHRONIC OSTEOMYELITIS		
43512	OPERATION ON SCAPULA, STERNUM, CLAVICLE, RIB, ULNA, RADIUS, METACARPUS, CARPUS, PHALANX, TIBIA, FIBULA, METATARSUS, TARSUS, MANDIBLE OR MAXILLA (other than alveolar margins) 1 BONE or ANY COMBINATION OF ADJOINING BONES (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
43515	OPERATION ON HUMERUS OR FEMUR 1 BONE (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
43518	OPERATION ON SPINE OR PELVIC BONES 1 BONE (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35	
43521	OPERATION ON SKULL (Anaes.) (Assist.) Fee: \$376.60 Benefit: 75% = \$282.45 85% = \$320.15	
43524	OPERATION ON ANY COMBINATION OF ADJOINING BONES, being bones referred to in item 43515 , 43518 or 43521 (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35	
SUBGROUP 11 - PAEDIATRIC		
SURGERY IN THE NEONATE OR YOUNG CHILD		
43801	INTESTINAL MALROTATION with or without volvulus, laparotomy for, not involving bowel resection (Anaes.) (Assist.) Fee: \$776.15 Benefit: 75% = \$582.15 85% = \$719.05	
43804	INTESTINAL MALROTATION with or without volvulus, laparotomy for, with bowel resection and anastomosis, with or without formation of stoma (Anaes.) (Assist.) Fee: \$826.40 Benefit: 75% = \$619.80 85% = \$769.30	
43807	DUODENAL ATRESIA or STENOSIS, duodenoduodenostomy or duodenojejunosostomy for (Anaes.) (Assist.) Fee: \$901.60 Benefit: 75% = \$676.20 85% = \$844.50	
43810	JEJUNAL ATRESIA, bowel resection and anastomosis for, with or without tapering (Anaes.) (Assist.) Fee: \$1,051.90 Benefit: 75% = \$788.95 85% = \$994.80	
43813	MECONIUM ILEUS, laparotomy for, complicated by 1 or more of associated volvulus, atresia, intestinal perforation with or without meconium peritonitis (Anaes.) (Assist.) Fee: \$1,051.90 Benefit: 75% = \$788.95 85% = \$994.80	

OPERATIONS		PAEDIATRIC
43816	ILEAL ATRESIA, COLONIC ATRESIA OR MECONIUM ILEUS not being a service associated with a service to which item 43813 applies, laparotomy for (Anaes.) (Assist.) Fee: \$976.70 Benefit: 75% = \$732.55 85% = \$919.60	
43819	HIRSCHSPRUNG'S DISEASE, laparotomy for, with or without frozen section biopsies and formation of stoma (Anaes.) (Assist.) Fee: \$788.90 Benefit: 75% = \$591.70 85% = \$731.80	
43822	ANORECTAL MALFORMATION, laparotomy and colostomy for (Anaes.) (Assist.) Fee: \$788.90 Benefit: 75% = \$591.70 85% = \$731.80	
43825	NEONATAL ALIMENTARY OBSTRUCTION, laparotomy for, not being a service to which any other item in this Subgroup applies (Anaes.) (Assist.) Fee: \$901.60 Benefit: 75% = \$676.20 85% = \$844.50	
43828	ACUTE NEONATAL NECROTISING ENTEROCOLITIS, laparotomy for, with resection, including any anastomoses or stoma formation (Anaes.) (Assist.) Fee: \$996.05 Benefit: 75% = \$747.05 85% = \$938.95	
43831	ACUTE NEONATAL NECROTISING ENTEROCOLITIS where no definitive procedure is possible, laparotomy for (Anaes.) (Assist.) Fee: \$776.15 Benefit: 75% = \$582.15 85% = \$719.05	
43834	BOWEL RESECTION for necrotising enterocolitis stricture or strictures, including any anastomoses or stoma formation (Anaes.) (Assist.) Fee: \$901.60 Benefit: 75% = \$676.20 85% = \$844.50	
43837	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, with diagnosis confirmed in the first 24 hours of life (Anaes.) (Assist.) Fee: \$1,126.95 Benefit: 75% = \$845.25 85% = \$1,069.85	
43840	CONGENITAL DIAPHRAGMATIC HERNIA, repair by thoracic or abdominal approach, diagnosed after the first day of life and before 20 days of age (Anaes.) (Assist.) Fee: \$976.70 Benefit: 75% = \$732.55 85% = \$919.60	
43843	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, not being a service to which item 43846 applies (Anaes.) (Assist.) Fee: \$1,502.60 Benefit: 75% = \$1,126.95 85% = \$1,445.50	
43846	OESOPHAGEAL ATRESIA (with or without repair of tracheo-oesophageal fistula), complete correction of, in infant of birth weight less than 1500 grams (Anaes.) (Assist.) Fee: \$1,615.25 Benefit: 75% = \$1,211.45 85% = \$1,558.15	
43849	OESOPHAGEAL ATRESIA, gastrostomy for (Anaes.) (Assist.) Fee: \$413.20 Benefit: 75% = \$309.90 85% = \$356.10	
43852	OESOPHAGEAL ATRESIA, thoracotomy for, and division of tracheo-oesophageal fistula without anastomosis (Anaes.) (Assist.) Fee: \$1,314.75 Benefit: 75% = \$986.10 85% = \$1,257.65	
43855	OESOPHAGEAL ATRESIA, delayed primary anastomosis for (Anaes.) (Assist.) Fee: \$1,389.95 Benefit: 75% = \$1,042.50 85% = \$1,332.85	
43858	OESOPHAGEAL ATRESIA, cervical oesophagostomy for (Anaes.) (Assist.) Fee: \$488.30 Benefit: 75% = \$366.25 85% = \$431.20	
43861	CONGENITAL CYSTADENOMATOID MALFORMATION OR CONGENITAL LOBAR EMPHYSEMA, thoracotomy and lung resection for (Anaes.) (Assist.) Fee: \$1,352.40 Benefit: 75% = \$1,014.30 85% = \$1,295.30	
43864	GASTROSCHISIS, operation for (Anaes.) (Assist.) Fee: \$1,014.25 Benefit: 75% = \$760.70 85% = \$957.15	
43867	GASTROSCHISIS, secondary operation for, with removal of silo and closure of abdominal wall (Anaes.) (Assist.) Fee: \$563.50 Benefit: 75% = \$422.65 85% = \$506.40	
43870	EXOMPHALOS containing small bowel only, operation for (Anaes.) (Assist.) Fee: \$788.90 Benefit: 75% = \$591.70 85% = \$731.80	

OPERATIONS		PAEDIATRIC
43873	EXOMPHALOS containing small bowel and other viscera, operation for (Anaes.) (Assist.) Fee: \$1,051.90 Benefit: 75% = \$788.95 85% = \$994.80	
43876	SACROCOCCYGEAL TERATOMA, excision of, by posterior approach (Anaes.) (Assist.) Fee: \$901.60 Benefit: 75% = \$676.20 85% = \$844.50	
43879	SACROCOCCYGEAL TERATOMA, excision of, by combined posterior and abdominal approach (Anaes.) (Assist.) Fee: \$1,051.90 Benefit: 75% = \$788.95 85% = \$994.80	
43882	CLOACAL EXSTROPHY, operation for (Anaes.) (Assist.) Fee: \$1,352.40 Benefit: 75% = \$1,014.30 85% = \$1,295.30	
THORACIC SURGERY		
43900	TRACHEO-OESOPHAGEAL FISTULA without atresia, division and repair of (Anaes.) (Assist.) Fee: \$901.60 Benefit: 75% = \$676.20 85% = \$844.50	
43903	OESOPHAGEAL ATRESIA or CORROSIVE OESOPHAGEAL STRICTURE, oesophageal replacement for, utilizing gastric tube, jejunum or colon (Anaes.) (Assist.) Fee: \$1,502.60 Benefit: 75% = \$1,126.95 85% = \$1,445.50	
43906	OESOPHAGUS, resection of congenital, anastomic or corrosive stricture and anastomosis, not being a service to which item 43903 applies (Anaes.) (Assist.) Fee: \$1,314.75 Benefit: 75% = \$986.10 85% = \$1,257.65	
43909	TRACHEOMALACIA, aortopexy for (Anaes.) (Assist.) Fee: \$1,314.75 Benefit: 75% = \$986.10 85% = \$1,257.65	
43912	THORACOTOMY and excision of 1 or more of bronchogenic or enterogenous cyst or mediastinal teratoma (Anaes.) (Assist.) Fee: \$1,242.10 Benefit: 75% = \$931.60 85% = \$1,185.00	
43915	EVENTRATION, plication of diaphragm for (Anaes.) (Assist.) Fee: \$939.15 Benefit: 75% = \$704.40 85% = \$882.05	
ABDOMINAL SURGERY		
43930	HYPERTROPHIC PYLORIC STENOSIS, pyloromyotomy for (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00	
43933	IDIOPATHIC INTUSSUSCEPTION, laparotomy and manipulative reduction of (Anaes.) (Assist.) Fee: \$422.70 Benefit: 75% = \$317.05 85% = \$365.60	
43936	INTUSSUSCEPTION, laparotomy and resection with anastomosis (Anaes.) (Assist.) Fee: \$788.90 Benefit: 75% = \$591.70 85% = \$731.80	
43939	VENTRAL HERNIA following neonatal closure of exomphalos or gastroschisis, repair of (Anaes.) (Assist.) Fee: \$601.05 Benefit: 75% = \$450.80 85% = \$543.95	
43942	ABDOMINAL WALL VITELLO INTESTINAL REMNANT, excision of (Anaes.) Fee: \$187.90 Benefit: 75% = \$140.95 85% = \$159.75	
43945	PATENT VITELLO INTESTINAL DUCT, excision of (Anaes.) (Assist.) Fee: \$788.90 Benefit: 75% = \$591.70 85% = \$731.80	
43948	UMBILICAL GRANULOMA, excision of, under general anaesthesia (Anaes.) Fee: \$112.75 Benefit: 75% = \$84.60 85% = \$95.85	
43951	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, without gastrostomy (Anaes.) (Assist.) Fee: \$706.45 Benefit: 75% = \$529.85 85% = \$649.35	
43954	GASTRO-OESOPHAGEAL REFLUX with or without hiatus hernia, laparotomy and fundoplication for, with gastrostomy (Anaes.) (Assist.) Fee: \$864.10 Benefit: 75% = \$648.10 85% = \$807.00	

OPERATIONS		AMPUTATIONS
	MISCELLANEOUS SURGERY	
44130	LYMPHADENECTOMY, for atypical mycobacterial infection or other granulomatous disease (Anaes.) (Assist.) Fee: \$375.65 Benefit: 75% = \$281.75 85% = \$319.35	
44133	TORTICOLLIS, open division of sternomastoid muscle for (Anaes.) (Assist.) Fee: \$298.15 Benefit: 75% = \$223.65 85% = \$253.45	
44136	INGROWN TOE NAIL, operation for, under general anaesthesia (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
	SUBGROUP 12 - AMPUTATIONS	
44325	HAND, MIDCARPAL OR TRANSMETACARPAL, amputation of (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
44328	HAND, FOREARM OR THROUGH ARM, amputation of (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
44331	AMPUTATION AT SHOULDER (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35	
44334	INTERSCAPULOTHORACIC AMPUTATION (Anaes.) (Assist.) Fee: \$968.30 Benefit: 75% = \$726.25 85% = \$911.20	
44338	1 DIGIT of foot, amputation of (Anaes.) Fee: \$116.80 Benefit: 75% = \$87.60 85% = \$99.30	
44342	2 DIGITS of 1 foot, amputation of (Anaes.) Fee: \$178.30 Benefit: 75% = \$133.75 85% = \$151.60	
44346	3 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$205.90 Benefit: 75% = \$154.45 85% = \$175.05	
44350	4 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$233.65 Benefit: 75% = \$175.25 85% = \$198.65	
44354	5 DIGITS of 1 foot, amputation of (Anaes.) (Assist.) Fee: \$267.40 Benefit: 75% = \$200.55 85% = \$227.30	
44358	TOE, including metatarsal or part of metatarsal each toe, amputation of (Anaes.) Fee: \$149.10 Benefit: 75% = \$111.85 85% = \$126.75	
44359	ONE OR MORE TOES OF ONE FOOT, amputation of, including if performed, excision of 1 or more metatarsal bones of the foot, performed for diabetic or other microvascular disease, excluding aftercare (Anaes.) (Assist.) Fee: \$213.95 Benefit: 75% = \$160.50 85% = \$181.90	
44361	FOOT AT ANKLE (Syme, Pirogoff types), amputation of (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65	
44364	FOOT, MIDTARSAL OR TRANSMETATARSAL, amputation of (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80	
44367	AMPUTATION THROUGH THIGH, AT KNEE OR BELOW KNEE (Anaes.) (Assist.) Fee: \$423.10 Benefit: 75% = \$317.35 85% = \$366.00	
44370	AMPUTATION AT HIP (Anaes.) (Assist.) Fee: \$583.95 Benefit: 75% = \$438.00 85% = \$526.85	

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
44373	HINDQUARTER, amputation of (Anaes.) (Assist.) Fee: \$1,198.70 Benefit: 75% = \$899.05 85% = \$1,141.60		
44376	AMPUTATION STUMP, reamputation of, to provide adequate skin and muscle cover (Assist.) Derived Fee: 75% of the original amputation fee		
SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY			
METICULOUS REPAIR DESIGNED TO OBTAIN MAXIMUM FUNCTIONAL RESULTS INCLUDING THE PREPARATION OF THE DEFECT REQUIRING REPAIR			
<i>(Note: See Explanatory notes to this Category for definition of "Local skin flap")</i>			
GENERAL			
45000	SINGLE STAGE LOCAL MUSCLE FLAP REPAIR, on eyelid, nose, lip, neck, hand, thumb, finger or genitals (Anaes.) Fee: \$438.95 Benefit: 75% = \$329.25 85% = \$381.85		
45003	SINGLE STAGE LOCAL MYOCUTANEOUS FLAP REPAIR to 1 defect, simple and small (Anaes.) Fee: \$487.75 Benefit: 75% = \$365.85 85% = \$430.65		
45006	SINGLE STAGE LARGE MYOCUTANEOUS FLAP REPAIR to 1 defect, (pectoralis major, latissimus dorsi, or similar large muscle) (Anaes.) (Assist.) Fee: \$841.35 Benefit: 75% = \$631.05 85% = \$784.25		
45009	SINGLE STAGE LOCAL muscle flap repair to 1 defect, simple and small (Anaes.) (Assist.) Fee: \$307.35 Benefit: 75% = \$230.55 85% = \$261.25		
45012	SINGLE STAGE LARGE MUSCLE FLAP REPAIR to 1 defect, (pectoralis major, gastrocnemius, gracilis or similar large muscle) (Anaes.) (Assist.) Fee: \$514.80 Benefit: 75% = \$386.10 85% = \$457.70		
45015	MUSCLE OR MYOCUTANEOUS FLAP, delay of (Anaes.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30		
45018	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) (Anaes.) (Assist.) Fee: \$384.05 Benefit: 75% = \$288.05 85% = \$326.95		
45019	FULL FACE CHEMICAL PEEL for severely sun-damaged skin, where it can be demonstrated that the damage affects 75% of the facial skin surface area involving photodamage (dermatoheliosis) typically consisting of solar keratoses, solar lentigines, freckling, yellowing and leathering of the skin, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital or approved day-hospital facility by a specialist in the practice of his or her specialty - 1 session only in a 12 month period (Anaes.) <i>(See para T8.65 of explanatory notes to this Category)</i> Fee: \$321.60 Benefit: 75% = \$241.20 85% = \$273.40		
45020	FULL FACE CHEMICAL PEEL for severe chloasma or melasma refractory to all other treatments, where it can be demonstrated that the chloasma or melasma affects 75% of the facial skin surface area involving diffuse pigmentation visible at a distance of 4 metres, where at least medium depth peeling agents are used, performed in the operating theatre of a hospital or approved day-hospital facility by a specialist in the practice of his or her specialty - 1 session only in a 12 month period (Anaes.) <i>(See para T8.65 of explanatory notes to this Category)</i> Fee: \$321.60 Benefit: 75% = \$241.20 85% = \$273.40		
45021	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) <i>(See para T8.66 of explanatory notes to this Category)</i> Fee: \$143.85 Benefit: 75% = \$107.90 85% = \$122.30		
45024	ABRASIVE THERAPY for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) <i>(See para T8.66 of explanatory notes to this Category)</i> Fee: \$323.10 Benefit: 75% = \$242.35 85% = \$274.65		
45025	CARBON DIOXIDE LASER OR ERBIUM LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - limited to 1 aesthetic area (Anaes.) <i>(See para T8.66 of explanatory notes to this Category)</i> Fee: \$143.85 Benefit: 75% = \$107.90 85% = \$122.30		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45026	CARBON DIOXIDE LASER OR ERBIUM LASER resurfacing of the face or neck for severely disfiguring scarring resulting from trauma, burns or acne - more than 1 aesthetic area (Anaes.) (See para T8.66 of explanatory notes to this Category) Fee: \$323.10 Benefit: 75% = \$242.35 85% = \$274.65		
45027	ANGIOMA, cauterisation of or injection into, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$97.55 Benefit: 75% = \$73.20 85% = \$82.95		
45030	ANGIOMA (haemangioma or lymphangioma or both) of skin and subcutaneous tissue (excluding facial muscle or breast) or mucous surface, small, excision and suture of (Anaes.) Fee: \$104.80 Benefit: 75% = \$78.60 85% = \$89.10		
45033	ANGIOMA, (haemangioma or lymphangioma or both), large or involving deeper tissue including facial muscle or breast, excision and suture of (Anaes.) Fee: \$195.10 Benefit: 75% = \$146.35 85% = \$165.85		
45035	ANGIOMA (haemangioma or lymphangioma or both), large and deep, involving muscles or nerves, excision of (Anaes.) (Assist.) Fee: \$569.20 Benefit: 75% = \$426.90 85% = \$512.10		
45036	ANGIOMA (haemangioma or lymphangioma or both) of neck, deep, excision of (Anaes.) (Assist.) Fee: \$914.55 Benefit: 75% = \$685.95 85% = \$857.45		
45039	ARTERIOVENOUS MALFORMATION (3 centimetres or less) of superficial tissue, excision of (Anaes.) Fee: \$195.10 Benefit: 75% = \$146.35 85% = \$165.85		
45042	ARTERIOVENOUS MALFORMATION, (greater than 3 centimetres), excision of (Anaes.) (Assist.) Fee: \$250.00 Benefit: 75% = \$187.50 85% = \$212.50		
45045	ARTERIOVENOUS MALFORMATION on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, excision of (Anaes.) Fee: \$250.00 Benefit: 75% = \$187.50 85% = \$212.50		
45048	LYMPHOEDEMATOUS tissue or lymphangiectasis, of lower leg and foot, or thigh, or upper arm, or forearm and hand, major excision of (Anaes.) (Assist.) Fee: \$627.95 Benefit: 75% = \$471.00 85% = \$570.85		
45051	CONTOUR RECONSTRUCTION for pathological deformity, insertion of foreign implant (non biological but excluding injection of liquid or semisolid material) by open operation (Anaes.) (Assist.) (See para T8.67 of explanatory notes to this Category) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05		
45054	LIMB OR CHEST, decompression escharotomy of (including all incisions), for acute compartment syndrome secondary to burn (Anaes.) (Assist.) (See para T8.68 of explanatory notes to this Category) Fee: \$199.45 Benefit: 75% = \$149.60 85% = \$169.55		
SKIN FLAP SURGERY			
<i>(Note: See Explanatory notes to this Category for definition of "Local skin flap")</i>			
45200	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, simple and small, excluding flap for male pattern baldness (Anaes.) (See para T8.69 of explanatory notes to this Category) Fee: \$230.55 Benefit: 75% = \$172.95 85% = \$196.00		
45203	SINGLE STAGE LOCAL FLAP, where indicated to repair 1 defect, complicated or large, excluding flap for male pattern baldness (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80		
45206	SINGLE STAGE LOCAL FLAP where indicated to repair 1 defect, on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals (Anaes.) Fee: \$311.00 Benefit: 75% = \$233.25 85% = \$264.35		
45209	DIRECT FLAP REPAIR (cross arm, abdominal or similar), first stage (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45442	FREE GRAFTING (split skin) to 1 defect, including elective dissection, extensive (Anaes.) (Assist.) Fee: \$475.45 Benefit: 75% = \$356.60 85% = \$418.35		
45445	FREE GRAFTING (split skin) as inlay graft to 1 defect including elective dissection using a mould (including insertion of, and removal of mould) (Anaes.) (Assist.) Fee: \$451.30 Benefit: 75% = \$338.50 85% = \$394.20		
45448	FREE GRAFTING (split skin) to 1 defect, including elective dissection on eyelid, nose, lip, ear, neck, hand, thumb, finger or genitals, not being a service to which item 45442 or 45445 applies (Anaes.) Fee: \$304.85 Benefit: 75% = \$228.65 85% = \$259.15		
45451	FREE GRAFTING (full thickness), to 1 defect, excluding grafts for male pattern baldness (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05		
45460	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>15 percent or more but less than 20 percent</i> of total body surface - one surgeon (Anaes.) (Assist.) Fee: \$1,016.20 Benefit: 75% = \$762.15 85% = \$959.10		
45461	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>15 percent or more but less than 20 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$724.20 Benefit: 75% = \$543.15 85% = \$667.10		
45462	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>15 percent or more but less than 20 percent</i> of total body surface - conjoint surgery, co- surgeon (Assist.) Fee: \$546.60 Benefit: 75% = \$409.95 85% = \$489.50		
45464	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>20 percent or more but less than 30 percent</i> of total body surface - one surgeon (Anaes.) (Assist.) Fee: \$1,551.10 Benefit: 75% = \$1,163.35 85% = \$1,494.00		
45465	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>20 percent or more but less than 30 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$1,105.05 Benefit: 75% = \$828.80 85% = \$1,047.95		
45466	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>20 percent or more but less than 30 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$833.35 Benefit: 75% = \$625.05 85% = \$776.25		
45468	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>30 percent or more but less than 40 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$1,485.85 Benefit: 75% = \$1,114.40 85% = \$1,428.75		
45469	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>30 percent or more but less than 40 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,121.00 Benefit: 75% = \$840.75 85% = \$1,063.90		
45471	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>40 percent or more but less than 50 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$1,867.70 Benefit: 75% = \$1,400.80 85% = \$1,810.60		
45472	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>40 percent or more but less than 50 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,408.80 Benefit: 75% = \$1,056.60 85% = \$1,351.70		
45474	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>50 percent or more but less than 60 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,248.55 Benefit: 75% = \$1,686.45 85% = \$2,191.45		
45475	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>50 percent or more but less than 60 percent</i> of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,696.55 Benefit: 75% = \$1,272.45 85% = \$1,639.45		
45477	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving <i>60 percent or more but less than 70 percent</i> of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$2,629.35 Benefit: 75% = \$1,972.05 85% = \$2,572.25		

OPERATIONS		PLASTIC & RECONSTRUCTIVE
45478	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 60 percent or more but less than 70 percent of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$1,983.20 Benefit: 75% = \$1,487.40 85% = \$1,926.10	
45480	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$3,010.10 Benefit: 75% = \$2,257.60 85% = \$2,953.00	
45481	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 70 percent or more but less than 80 percent of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,271.00 Benefit: 75% = \$1,703.25 85% = \$2,213.90	
45483	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, principal surgeon (Anaes.) (Assist.) Fee: \$3,429.50 Benefit: 75% = \$2,572.15 85% = \$3,372.40	
45484	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - involving 80 percent or more of total body surface - conjoint surgery, co-surgeon (Assist.) Fee: \$2,587.60 Benefit: 75% = \$1,940.70 85% = \$2,530.50	
45485	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - upper eyelid, nose, lip, ear or palm of the hand (Anaes.) (Assist.) Fee: \$427.85 Benefit: 75% = \$320.90 85% = \$370.75	
45486	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - forehead, cheek, anterior aspect of the neck, chin, plantar aspect of the foot, heel or genitalia (Anaes.) (Assist.) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95	
45487	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of toe (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80	
45488	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 1 digit of the hand (Anaes.) (Assist.) Fee: \$365.80 Benefit: 75% = \$274.35 85% = \$310.95	
45489	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 2 digits of the hand (Anaes.) (Assist.) Fee: \$548.80 Benefit: 75% = \$411.60 85% = \$491.70	
45490	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 3 digits of the hand (Anaes.) (Assist.) Fee: \$731.70 Benefit: 75% = \$548.80 85% = \$674.60	
45491	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 4 digits of the hand (Anaes.) (Assist.) Fee: \$914.55 Benefit: 75% = \$685.95 85% = \$857.45	
45492	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - the whole of 5 digits of the hand (Anaes.) (Assist.) Fee: \$1,097.50 Benefit: 75% = \$823.15 85% = \$1,040.40	
45493	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - portion of digit of hand (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80	
45494	FREE GRAFTING (split skin) to burns, including excision of burnt tissue - whole of face (excluding ears) (Anaes.) (Assist.) Fee: \$1,328.60 Benefit: 75% = \$996.45 85% = \$1,271.50	
OTHER GRAFTS AND MISCELLANEOUS PROCEDURES		
45496	FLAP, free tissue transfer using microvascular techniques - revision of , by open operation (Anaes.) Fee: \$337.30 Benefit: 75% = \$253.00 85% = \$286.75	
45497	FLAP, free tissue transfer using microvascular techniques - complete revision of , by liposuction (Anaes.) Fee: \$263.50 Benefit: 75% = \$197.65 85% = \$224.00	
45498	FLAP, free tissue transfer using microvascular techniques - staged revision of , by liposuction - first stage (Anaes.) Fee: \$212.00 Benefit: 75% = \$159.00 85% = \$180.20	
45499	FLAP, free tissue transfer using microvascular techniques - staged revision of , by liposuction - second stage (Anaes.) Fee: \$158.10 Benefit: 75% = \$118.60 85% = \$134.40	

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45500	MICROVASCULAR REPAIR using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) Fee: \$884.00	Benefit: 75% = \$663.00	85% = \$826.90
45501	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) Fee: \$1,438.95	Benefit: 75% = \$1,079.25	85% = \$1,381.85
45502	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for re-implantation of limb or digit (Anaes.) (Assist.) Fee: \$1,438.95	Benefit: 75% = \$1,079.25	85% = \$1,381.85
45503	MICRO-ARTERIAL OR MICRO-VEINOUS GRAFT using microsurgical techniques (Anaes.) (Assist.) Fee: \$1,646.20	Benefit: 75% = \$1,234.65	85% = \$1,589.10
45504	MICROVASCULAR ANASTOMOSIS of artery using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) Fee: \$1,438.95	Benefit: 75% = \$1,079.25	85% = \$1,381.85
45505	MICROVASCULAR ANASTOMOSIS of vein using microsurgical techniques, for free transfer of tissue including setting in of free flap (Anaes.) (Assist.) Fee: \$1,438.95	Benefit: 75% = \$1,079.25	85% = \$1,381.85
45506	SCAR, of face or neck, not more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) Fee: \$178.30	Benefit: 75% = \$133.75	85% = \$151.60
45512	SCAR, of face or neck, more than 3 cm in length, revision of, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) Fee: \$239.75	Benefit: 75% = \$179.85	85% = \$203.80
45515	SCAR, other than on face or neck, not more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) Fee: \$151.20	Benefit: 75% = \$113.40	85% = \$128.55
45518	SCAR, other than on face or neck, more than 7 cms in length, revision of, as an independent procedure, where undertaken in the operating theatre of a hospital or approved day-hospital facility, or where performed by a specialist in the practice of his or her specialty (Anaes.) Fee: \$182.95	Benefit: 75% = \$137.25	85% = \$155.55
45519	EXTENSIVE BURN SCARS OF SKIN (more than 1 percent of body surface area), excision of, for correction of scar contracture (Anaes.) (Assist.) Fee: \$347.85	Benefit: 75% = \$260.90	85% = \$295.70
45520	REDUCTION MAMMAPLASTY (unilateral) with surgical repositioning of nipple (Anaes.) (Assist.) Fee: \$730.05	Benefit: 75% = \$547.55	85% = \$672.95
45522	REDUCTION MAMMAPLASTY (unilateral) without surgical repositioning of nipple (Anaes.) (Assist.) Fee: \$512.20	Benefit: 75% = \$384.15	85% = \$455.10
45524	MAMMAPLASTY, AUGMENTATION, for significant breast asymmetry where the augmentation is limited to 1 breast (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$601.30	Benefit: 75% = \$451.00	85% = \$544.20
45527	MAMMAPLASTY, AUGMENTATION, (unilateral), following mastectomy (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$601.30	Benefit: 75% = \$451.00	85% = \$544.20
45528	MAMMAPLASTY, AUGMENTATION, bilateral, not being a service to which Item 45524 or 45527 applies, where it can be demonstrated that surgery is indicated because of disease, trauma or congenital malformation of the breast (Anaes.) (Assist.) <i>(See para T8.71 of explanatory notes to this Category)</i> Fee: \$901.90	Benefit: 75% = \$676.45	85% = \$844.80

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45530	BREAST RECONSTRUCTION (unilateral) using a latissimus dorsi or other large muscle or myocutaneous flap, including repair of secondary skin defect, if required, excluding repair of muscular aponeurotic layer (Anaes.) (Assist.) <i>(See para T8.72 of explanatory notes to this Category)</i>	Fee: \$891.35	Benefit: 75% = \$668.55 85% = \$834.25
45533	BREAST RECONSTRUCTION using breast sharing technique (first stage) including breast reduction, transfer of complex skin and breast tissue flap, split skin graft to pedicle of flap or other similar procedure (Anaes.) (Assist.)	Fee: \$1,009.45	Benefit: 75% = \$757.10 85% = \$952.35
45536	BREAST RECONSTRUCTION using breast sharing technique (second stage) including division of pedicle, inseting of breast flap, with closure of donor site or other similar procedure (Anaes.) (Assist.)	Fee: \$371.20	Benefit: 75% = \$278.40 85% = \$315.55
45539	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.)	Fee: \$868.55	Benefit: 75% = \$651.45 85% = \$811.45
45542	BREAST RECONSTRUCTION (unilateral), following mastectomy, using tissue expansion - removal of tissue expansion unit and insertion of permanent prosthesis (Anaes.) (Assist.)	Fee: \$497.30	Benefit: 75% = \$373.00 85% = \$440.20
45545	NIPPLE OR AREOLA or both, reconstruction of, by any surgical technique (Anaes.) (Assist.) <i>(See para T8.74 of explanatory notes to this Category)</i>	Fee: \$504.75	Benefit: 75% = \$378.60 85% = \$447.65
45546	NIPPLE OR AREOLA or both, intradermal colouration of, following breast reconstruction after mastectomy or for congenital absence of nipple <i>(See para T8.74 of explanatory notes to this Category)</i>	Fee: \$160.45	Benefit: 75% = \$120.35 85% = \$136.40
45548	BREAST PROSTHESIS, removal of, as an independent procedure (Anaes.)	Fee: \$224.35	Benefit: 75% = \$168.30 85% = \$190.70
45551	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule (Anaes.) (Assist.)	Fee: \$359.70	Benefit: 75% = \$269.80 85% = \$305.75
45552	BREAST PROSTHESIS, removal of, with complete excision of fibrous capsule and replacement of prosthesis (Anaes.) (Assist.)	Fee: \$517.85	Benefit: 75% = \$388.40 85% = \$460.75
45554	BREAST PROSTHESIS, replacement of, following medical complications (such as rupture, migration of prosthetic material, or capsule formation), where new pocket is formed, including excision of fibrous capsule (Anaes.) (Assist.)	Fee: \$567.10	Benefit: 75% = \$425.35 85% = \$510.00
45555	SILICONE BREAST PROSTHESIS, removal of and replacement with prosthesis other than silicone gel prosthesis (Anaes.) (Assist.)	Fee: \$517.85	Benefit: 75% = \$388.40 85% = \$460.75
45556	BREAST PTOSIS, correction of (unilateral), to match the position of the contralateral breast (Anaes.) (Assist.) <i>(See para T8.73 of explanatory notes to this Category)</i>	Fee: \$621.05	Benefit: 75% = \$465.80 85% = \$563.95
45557	BREAST PTOSIS, correction of (unilateral), following pregnancy and lactation, when performed within 6 years of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) <i>(See para T8.73 of explanatory notes to this Category)</i>	Fee: \$621.05	Benefit: 75% = \$465.80 85% = \$563.95
45558	BREAST PTOSIS, correction of (bilateral), following pregnancy and lactation, when performed within 6 years of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) <i>(See para T8.73 of explanatory notes to this Category)</i>	Fee: \$931.55	Benefit: 75% = \$698.70 85% = \$874.45
45560	HAIR TRANSPLANTATION for the treatment of alopecia of congenital or traumatic origin or due to disease, excluding male pattern baldness, not being a service to which another item in this Group applies (Anaes.)	Fee: \$384.05	Benefit: 75% = \$288.05 85% = \$326.95

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45562	FREE TRANSFER OF TISSUE involving raising of tissue on vascular or neurovascular pedicle, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) Fee: \$891.35 Benefit: 75% = \$668.55 85% = \$834.25		
45563	NEUROVASCULAR ISLAND FLAP, including direct repair of secondary cutaneous defect if performed, excluding flap for male pattern baldness (Anaes.) (Assist.) Fee: \$891.35 Benefit: 75% = \$668.55 85% = \$834.25		
45564	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 45501 , 45502 , 45504 , 45505 or 45562 applies - conjoint surgery, principal specialist surgeon (Anaes.) (Assist.) Fee: \$2,064.45 Benefit: 75% = \$1,548.35 85% = \$2,007.35		
45565	FREE TRANSFER OF TISSUE reconstructive surgery for the repair of major tissue defect due to congenital deformity, surgery or trauma, involving anastomoses of vessels using microvascular techniques and including raising of tissue on a vascular or neurovascular pedicle, preparation of recipient vessels, transfer of tissue, inseting of tissue at recipient site and direct repair of secondary cutaneous defect if performed, not being a service associated with a service to which item 45501, 45502, 45504, 45505 or 45562 applies - conjoint surgery, conjoint specialist surgeon (Assist.) Fee: \$1,548.40 Benefit: 75% = \$1,161.30 85% = \$1,491.30		
45566	TISSUE EXPANSION not being a service to which item 45539 or 45542 applies - insertion of tissue expansion unit and all attendances for subsequent expansion injections (Anaes.) (Assist.) Fee: \$868.55 Benefit: 75% = \$651.45 85% = \$811.45		
45572	INTRA OPERATIVE TISSUE EXPANSION performed during an operation when combined with a service to which another item in Group T8 applies including expansion injections and excluding treatment of male pattern baldness (Anaes.) Fee: \$236.55 Benefit: 75% = \$177.45 85% = \$201.10		
45575	FACIAL NERVE PARALYSIS, free fascia graft for (Anaes.) (Assist.) Fee: \$583.95 Benefit: 75% = \$438.00 85% = \$526.85		
45578	FACIAL NERVE PARALYSIS, muscle transfer for (Anaes.) (Assist.) Fee: \$676.30 Benefit: 75% = \$507.25 85% = \$619.20		
45581	FACIAL NERVE PALSY, excision of tissue for (Anaes.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70		
45584	LIPOSUCTION (suction assisted lipolysis) to 1 regional area (thigh, buttock, or similar), for treatment of post-traumatic pseudolipoma (Anaes.) <i>(See para T8.75 of explanatory notes to this Category)</i> Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
45585	LIPOSUCTION (suction assisted lipolysis) to 1 regional area, not being a service to which item 45584 applies, <i>where it can be demonstrated that the treatment is for pathological lipodystrophy of hips, buttocks, thighs and lower legs (including knees), gynaecomastia, lymphoedema or similar conditions</i> (Anaes.) <i>(See para T8.75 of explanatory notes to this Category)</i> Fee: \$512.20 Benefit: 75% = \$384.15 85% = \$455.10		
45587	MELOPLASTY for correction of facial asymmetry due to soft tissue abnormality where the meloplasty is limited to 1 side of the face (Anaes.) (Assist.) <i>(See para T8.76 of explanatory notes to this Category)</i> Fee: \$722.30 Benefit: 75% = \$541.75 85% = \$665.20		
45588	MELOPLASTY, bilateral, not being a service to which Item 45587 applies, <i>where it can be demonstrated that surgery is indicated because of disease, trauma or congenital conditions</i> (Anaes.) (Assist.) <i>(See para T8.76 of explanatory notes to this Category)</i> Fee: \$1,083.50 Benefit: 75% = \$812.65 85% = \$1,026.40		
45590	ORBITAL CAVITY, reconstruction of a wall or floor, with or without foreign implant (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70		
45593	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) Fee: \$460.25 Benefit: 75% = \$345.20 85% = \$403.15		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45596	MAXILLA, total resection of (Anaes.) (Assist.) Fee: \$730.05 Benefit: 75% = \$547.55 85% = \$672.95		
45597	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) Fee: \$977.25 Benefit: 75% = \$732.95 85% = \$920.15		
45599	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) Fee: \$759.35 Benefit: 75% = \$569.55 85% = \$702.25		
45602	MANDIBLE, including lower border, OR MAXILLA, sub-total resection of (Anaes.) (Assist.) Fee: \$567.10 Benefit: 75% = \$425.35 85% = \$510.00		
45605	MANDIBLE OR MAXILLA, segmental resection of, for tumours or cysts (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35		
45608	MANDIBLE, hemimandibular reconstruction with bone graft, not being a service associated with a service to which item 45599 applies (Anaes.) (Assist.) Fee: \$670.70 Benefit: 75% = \$503.05 85% = \$613.60		
45611	MANDIBLE, condylectomy (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05		
45614	EYELID, WHOLE THICKNESS RECONSTRUCTION OF other than by direct suture only (Anaes.) (Assist.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35		
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 posttraumatic scarring, or the restoration of symmetry of contralateral upper eyelid in respect of 1 of these conditions (Anaes.) <i>(See para T8.77 of explanatory notes to this Category)</i> Fee: \$190.60 Benefit: 75% = \$142.95 85% = \$162.05		
45620	LOWER EYELID, REDUCTION OF, for herniation of orbital fat in exophthalmos, facial nerve palsy or posttraumatic scarring, or, in respect of 1 of these conditions, the restoration of symmetry of the contralateral lower eyelid (Anaes.) <i>(See para T8.77 of explanatory notes to this Category)</i> Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70		
45623	PTOSIS of eyelid (unilateral), correction of (Anaes.) (Assist.) Fee: \$586.30 Benefit: 75% = \$439.75 85% = \$529.20		
45624	PTOSIS of eyelid, correction of, where previous ptosis surgery has been performed on that side (Anaes.) (Assist.) Fee: \$760.05 Benefit: 75% = \$570.05 85% = \$702.95		
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.) Fee: \$152.05 Benefit: 75% = \$114.05 85% = \$129.25		
45626	ECTROPION OR ENTROPION, correction of (unilateral) (Anaes.) Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70		
45629	SYMBLEPHARON, grafting for (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05		
45632	RHINOPLASTY, correction of lateral or alar cartilages (Anaes.) Fee: \$415.00 Benefit: 75% = \$311.25 85% = \$357.90		
45635	RHINOPLASTY, correction of bony vault only (Anaes.) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35		
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.) <i>(See para T8.78 of explanatory notes to this Category)</i> Fee: \$822.20 Benefit: 75% = \$616.65 85% = \$765.10		
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.) <i>(See para T8.78 of explanatory notes to this Category)</i> Fee: \$822.20 Benefit: 75% = \$616.65 85% = \$765.10		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45641	RHINOPLASTY involving nasal or septal cartilage graft, or nasal bone graft, or nasal bone and nasal cartilage graft (Anaes.) Fee: \$877.95 Benefit: 75% = \$658.50 85% = \$820.85		
45644	RHINOPLASTY involving autogenous bone or cartilage graft obtained from distant donor site, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,037.35 Benefit: 75% = \$778.05 85% = \$980.25		
45645	CHOANAL ATRESIA, repair of by puncture and dilatation (Anaes.) Fee: \$181.30 Benefit: 75% = \$136.00 85% = \$154.15		
45646	CHOANAL ATRESIA - correction by open operation with bone removal (Anaes.) (Assist.) Fee: \$730.05 Benefit: 75% = \$547.55 85% = \$672.95		
45647	FACE, contour restoration of 1 region, using autogenous bone or cartilage graft (not being a service to which item 45644 applies) (Anaes.) (Assist.) Fee: \$1,037.35 Benefit: 75% = \$778.05 85% = \$980.25		
45650	RHINOPLASTY, secondary revision of (Anaes.) Fee: \$119.85 Benefit: 75% = \$89.90 85% = \$101.90		
45652	RHINOPHYMA, carbon dioxide laser or erbium laser excision-ablation of (Anaes.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65		
45653	RHINOPHYMA, shaving of (Anaes.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65		
45656	COMPOSITE GRAFT (Chondrocutaneous or chondromucosal) to nose, ear or eyelid (Anaes.) (Assist.) Fee: \$407.25 Benefit: 75% = \$305.45 85% = \$350.15		
45659	LOP EAR, BAT EAR OR SIMILAR DEFORMITY, correction of (Anaes.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50		
45660	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, using multiple costal cartilage grafts to form a framework, including the harvesting and sculpturing of the cartilage and its insertion, for congenital absence, microtia or post-traumatic loss of entire or substantial portion of pinna (first stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) Fee: \$2,334.05 Benefit: 75% = \$1,750.55 85% = \$2,276.95		
45661	EXTERNAL EAR, COMPLEX TOTAL RECONSTRUCTION OF, elevation of costal cartilage framework using cartilage previously stored in abdominal wall, including the use of local skin and fascia flaps and full thickness skin graft to cover cartilage (second stage) - performed by a specialist in the practice of his or her specialty (Anaes.) (Assist.) Fee: \$1,037.35 Benefit: 75% = \$778.05 85% = \$980.25		
45662	CONGENITAL ATRESIA, reconstruction of external auditory canal (Anaes.) (Assist.) Fee: \$568.55 Benefit: 75% = \$426.45 85% = \$511.45		
45665	LIP, EYELID OR EAR, FULL THICKNESS WEDGE EXCISION OF, with repair by direct sutures (Anaes.) Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70		
45668	VERMILIONECTOMY, by surgical excision (Anaes.) Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70		
45669	VERMILIONECTOMY, using carbon dioxide laser or erbium laser excision-ablation (Anaes.) <i>(See para T8.79 of explanatory notes to this Category)</i> Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70		
45671	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$676.30 Benefit: 75% = \$507.25 85% = \$619.20		
45674	LIP OR EYELID RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$196.70 Benefit: 75% = \$147.55 85% = \$167.20		
45675	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70		
45676	MACROSTOMIA, operation for (Anaes.) (Assist.) Fee: \$466.45 Benefit: 75% = \$349.85 85% = \$409.35		

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45677	CLEFT LIP, unilateral primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$438.95	Benefit: 75% = \$329.25	85% = \$381.85
45680	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$548.80	Benefit: 75% = \$411.60	85% = \$491.70
45683	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$609.65	Benefit: 75% = \$457.25	85% = \$552.55
45686	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$719.50	Benefit: 75% = \$539.65	85% = \$662.40
45689	CLEFT LIP, lip adhesion procedure, unilateral or bilateral (Anaes.) (Assist.) Fee: \$212.20	Benefit: 75% = \$159.15	85% = \$180.40
45692	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) Fee: \$243.85	Benefit: 75% = \$182.90	85% = \$207.30
45695	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) Fee: \$396.25	Benefit: 75% = \$297.20	85% = \$339.15
45698	CLEFT LIP, primary columella lengthening procedure, bilateral (Anaes.) Fee: \$371.90	Benefit: 75% = \$278.95	85% = \$316.15
45701	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$670.70	Benefit: 75% = \$503.05	85% = \$613.60
45704	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$243.85	Benefit: 75% = \$182.90	85% = \$207.30
45707	CLEFT PALATE, primary repair (Anaes.) (Assist.) Fee: \$634.00	Benefit: 75% = \$475.50	85% = \$576.90
45710	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) Fee: \$396.25	Benefit: 75% = \$297.20	85% = \$339.15
45713	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) Fee: \$451.30	Benefit: 75% = \$338.50	85% = \$394.20
45714	ORO-NASAL FISTULA, plastic closure of, including services to which item 45200 , 45203 or 45239 applies (Anaes.) (Assist.) Fee: \$634.00	Benefit: 75% = \$475.50	85% = \$576.90
45716	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) Fee: \$634.00	Benefit: 75% = \$475.50	85% = \$576.90
45720	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) <i>(See para T8.80 of explanatory notes to this Category)</i> Fee: \$783.85	Benefit: 75% = \$587.90	85% = \$726.75
45723	MANDIBLE OR MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) <i>(See para T8.80 of explanatory notes to this Category)</i> Fee: \$884.00	Benefit: 75% = \$663.00	85% = \$826.90
45726	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) <i>(See para T8.80 of explanatory notes to this Category)</i> Fee: \$998.95	Benefit: 75% = \$749.25	85% = \$941.85
45729	MANDIBLE OR MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) <i>(See para T8.80 of explanatory notes to this Category)</i> Fee: \$1,121.80	Benefit: 75% = \$841.35	85% = \$1,064.70

OPERATIONS		PLASTIC & RECONSTRUCTIVE	
45731	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,137.25	Benefit: 75% = \$852.95 85% = \$1,080.15
45732	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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,280.40	Benefit: 75% = \$960.30 85% = \$1,223.30
45735	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.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,306.20	Benefit: 75% = \$979.65 85% = \$1,249.10
45738	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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,469.40	Benefit: 75% = \$1,102.05 85% = \$1,412.30
45741	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.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,436.95	Benefit: 75% = \$1,077.75 85% = \$1,379.85
45744	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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,615.60	Benefit: 75% = \$1,211.70 85% = \$1,558.50
45747	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.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,567.65	Benefit: 75% = \$1,175.75 85% = \$1,510.55
45752	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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para T8.80 of explanatory notes to this Category)	Fee: \$1,755.95	Benefit: 75% = \$1,317.00 85% = \$1,698.85
45753	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.)	Fee: \$1,766.45	Benefit: 75% = \$1,324.85 85% = \$1,709.35
45754	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.)	Fee: \$2,117.40	Benefit: 75% = \$1,588.05 85% = \$2,060.30
45755	TEMPOROMANDIBULAR MENISCECTOMY (Anaes.) (Assist.)	Fee: \$298.15	Benefit: 75% = \$223.65 85% = \$253.45
45758	TEMPORO-MANDIBULAR JOINT, arthroplasty (Anaes.) (Assist.)	Fee: \$533.55	Benefit: 75% = \$400.20 85% = \$476.45
45761	GENIOPLASTY, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para T8.81 of explanatory notes to this Category)	Fee: \$607.00	Benefit: 75% = \$455.25 85% = \$549.90

OPERATIONS		HAND SURGERY	
45767	HYPERTELORISM, correction of, intracranial (Anaes.) (Assist.) Fee: \$2,036.35 Benefit: 75% = \$1,527.30 85% = \$1,979.25		
45770	HYPERTELORISM, correction of, subcranial (Anaes.) (Assist.) Fee: \$1,559.85 Benefit: 75% = \$1,169.90 85% = \$1,502.75		
45773	TREACHER COLLINS SYNDROME, PERIORBITAL CORRECTION OF, with rib and iliac bone grafts (Anaes.) (Assist.) Fee: \$1,421.60 Benefit: 75% = \$1,066.20 85% = \$1,364.50		
45776	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, intracranial (Anaes.) (Assist.) Fee: \$1,421.60 Benefit: 75% = \$1,066.20 85% = \$1,364.50		
45779	ORBITAL DYSTOPIA (UNILATERAL), CORRECTION OF, with total repositioning of 1 orbit, extracranial (Anaes.) (Assist.) Fee: \$1,045.10 Benefit: 75% = \$783.85 85% = \$988.00		
45782	FRONTOORBITAL ADVANCEMENT, UNILATERAL (Anaes.) (Assist.) Fee: \$799.20 Benefit: 75% = \$599.40 85% = \$742.10		
45785	CRANIAL VAULT RECONSTRUCTION for oxycephaly, brachycephaly, turricephaly or similar condition (bilateral frontoorbital advancement) (Anaes.) (Assist.) Fee: \$1,352.45 Benefit: 75% = \$1,014.35 85% = \$1,295.35		
45788	GLENOID FOSSA, ZYGOMATIC ARCH AND TEMPORAL BONE, RECONSTRUCTION OF, (Obwegeser technique) (Anaes.) (Assist.) Fee: \$1,337.00 Benefit: 75% = \$1,002.75 85% = \$1,279.90		
45791	ABSENT CONDYLE AND ASCENDING RAMUS in hemifacial microsomia, CONSTRUCTION OF, not including harvesting of graft material (Anaes.) (Assist.) Fee: \$722.30 Benefit: 75% = \$541.75 85% = \$665.20		
45794	OSSEO-INTEGRATION PROCEDURE - extra-oral, implantation of titanium fixture (Anaes.) Fee: \$408.55 Benefit: 75% = \$306.45 85% = \$351.45		
45797	OSSEO-INTEGRATION PROCEDURE, fixation of transcutaneous abutment (Anaes.) Fee: \$151.20 Benefit: 75% = \$113.40 85% = \$128.55		
SUBGROUP 14 - HAND SURGERY			
<i>Note: Items 46300 to 46534 are restricted to surgery on the hand/s.</i>			
46300	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$274.35 Benefit: 75% = \$205.80 85% = \$233.20		
46303	CARPOMETACARPAL JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$304.95 Benefit: 75% = \$228.75 85% = \$259.25		
46306	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, interposition arthroplasty of and including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) Fee: \$426.85 Benefit: 75% = \$320.15 85% = \$369.75		
46307	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT - volar plate arthroplasty for traumatic deformity including tendon transfers or realignment on the 1 ray (Anaes.) (Assist.) Fee: \$426.85 Benefit: 75% = \$320.15 85% = \$369.75		
46309	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 1 joint (Anaes.) (Assist.) Fee: \$426.85 Benefit: 75% = \$320.15 85% = \$369.75		
46312	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 2 joints (Anaes.) (Assist.) Fee: \$548.90 Benefit: 75% = \$411.70 85% = \$491.80		
46315	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 3 joints (Anaes.) (Assist.) Fee: \$731.75 Benefit: 75% = \$548.85 85% = \$674.65		

OPERATIONS		HAND SURGERY
46318	INTERPHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 4 joints (Anaes.) (Assist.) Fee: \$914.75 Benefit: 75% = \$686.10 85% = \$857.65	
46321	INTERPHALANGEAL JOINT OR METACARPOPHALANGEAL JOINT, total replacement arthroplasty or hemiarthroplasty of, including associated synovectomy, tendon transfer or realignment - 5 or more joints (Anaes.) (Assist.) Fee: \$1,097.70 Benefit: 75% = \$823.30 85% = \$1,040.60	
46324	CARPAL BONE REPLACEMENT ARTHROPLASTY including associated tendon transfer or realignment when performed (Anaes.) (Assist.) Fee: \$654.60 Benefit: 75% = \$490.95 85% = \$597.50	
46325	CARPAL BONE REPLACEMENT OR RESECTION ARTHROPLASTY using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed (Anaes.) (Assist.) Fee: \$683.05 Benefit: 75% = \$512.30 85% = \$625.95	
46327	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of (Anaes.) Fee: \$164.75 Benefit: 75% = \$123.60 85% = \$140.05	
46330	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, arthrotomy of, with ligamentous or capsular repair (Anaes.) (Assist.) Fee: \$280.60 Benefit: 75% = \$210.45 85% = \$238.55	
46333	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, ligamentous repair of, using free tissue graft or implant (Anaes.) (Assist.) Fee: \$457.35 Benefit: 75% = \$343.05 85% = \$400.25	
46336	INTER-PHALANGEAL JOINT or METACARPOPHALANGEAL JOINT, synovectomy, capsulectomy or debridement of, not being a service associated with any procedure related to that joint (Anaes.) (Assist.) Fee: \$213.50 Benefit: 75% = \$160.15 85% = \$181.50	
46339	EXTENSOR TENDONS or FLEXOR TENDONS of hand or wrist, synovectomy of (Anaes.) (Assist.) Fee: \$378.00 Benefit: 75% = \$283.50 85% = \$321.30	
46342	DISTAL RADIOULNAR JOINT or CARPOMETACARPAL JOINT OR JOINTS, synovectomy of (Anaes.) (Assist.) Fee: \$378.00 Benefit: 75% = \$283.50 85% = \$321.30	
46345	DISTAL RADIOULNAR JOINT, reconstruction or stabilisation of, including fusion, or ligamentous arthroplasty and excision of distal ulna, when performed (Anaes.) (Assist.) Fee: \$457.35 Benefit: 75% = \$343.05 85% = \$400.25	
46348	DIGIT, synovectomy of flexor tendon or tendons - 1 digit (Anaes.) Fee: \$198.20 Benefit: 75% = \$148.65 85% = \$168.50	
46351	DIGIT, synovectomy of flexor tendon or tendons - 2 digits (Anaes.) (Assist.) Fee: \$295.75 Benefit: 75% = \$221.85 85% = \$251.40	
46354	DIGIT, synovectomy of flexor tendon or tendons - 3 digits (Anaes.) (Assist.) Fee: \$396.35 Benefit: 75% = \$297.30 85% = \$339.25	
46357	DIGIT, synovectomy of flexor tendon or tendons - 4 digits (Anaes.) (Assist.) Fee: \$493.95 Benefit: 75% = \$370.50 85% = \$436.85	
46360	DIGIT, synovectomy of flexor tendon or tendons - 5 digits (Anaes.) (Assist.) Fee: \$594.55 Benefit: 75% = \$445.95 85% = \$537.45	
46363	TENDON SHEATH OF HAND OR WRIST, open operation on, for STENOSING TENOVAGINITIS (Anaes.) Fee: \$170.75 Benefit: 75% = \$128.10 85% = \$145.15	
46366	DUPUYTREN'S CONTRACTURE, subcutaneous fasciotomy for - each band (Anaes.) Fee: \$103.70 Benefit: 75% = \$77.80 85% = \$88.15	
46369	DUPUYTREN'S CONTRACTURE, palmar fasciectomy for - 1 hand (Anaes.) Fee: \$170.75 Benefit: 75% = \$128.10 85% = \$145.15	
46372	DUPUYTREN'S CONTRACTURE, fasciectomy for, from 1 ray, including dissection of nerves - 1 hand (Anaes.) (Assist.) Fee: \$346.95 Benefit: 75% = \$260.25 85% = \$294.95	

OPERATIONS		HAND SURGERY	
46435	FLEXOR TENDON OF HAND, secondary repair of, distal to A1 pulley, each tendon (Anaes.) (Assist.) Fee: \$426.85 Benefit: 75% = \$320.15 85% = \$369.75		
46438	MALLET FINGER, closed pin fixation of (Anaes.) Fee: \$109.80 Benefit: 75% = \$82.35 85% = \$93.35		
46441	MALLET FINGER, open repair of, including pin fixation when performed (Anaes.) (Assist.) Fee: \$265.25 Benefit: 75% = \$198.95 85% = \$225.50		
46442	MALLET FINGER with intra articular fracture involving more than one third of base of terminal phalanx - open reduction (Anaes.) (Assist.) Fee: \$227.70 Benefit: 75% = \$170.80 85% = \$193.55		
46444	BOUTONNIERE DEFORMITY without joint contracture, reconstruction of (Anaes.) (Assist.) Fee: \$396.35 Benefit: 75% = \$297.30 85% = \$339.25		
46447	BOUTONNIERE DEFORMITY with joint contracture, reconstruction of (Anaes.) (Assist.) Fee: \$493.95 Benefit: 75% = \$370.50 85% = \$436.85		
46450	EXTENSOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$155.55		
46453	FLEXOR TENDON, TENOLYSIS OF, following tendon injury, repair or graft (Anaes.) (Assist.) Fee: \$304.95 Benefit: 75% = \$228.75 85% = \$259.25		
46456	FINGER, percutaneous tenotomy of (Anaes.) Fee: \$79.25 Benefit: 75% = \$59.45 85% = \$67.40		
46459	OPERATION for OSTEOMYELITIS on distal phalanx (Anaes.) Fee: \$152.50 Benefit: 75% = \$114.40 85% = \$129.65		
46462	OPERATION for OSTEOMYELITIS on middle or proximal phalanx, metacarpal or carpus (Anaes.) (Assist.) Fee: \$243.90 Benefit: 75% = \$182.95 85% = \$207.35		
46464	AMPUTATION of a supernumerary complete digit (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$155.55		
46465	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$155.55		
46468	AMPUTATION of 2 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$320.15 Benefit: 75% = \$240.15 85% = \$272.15		
46471	AMPUTATION of 3 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$457.35 Benefit: 75% = \$343.05 85% = \$400.25		
46474	AMPUTATION of 4 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$594.55 Benefit: 75% = \$445.95 85% = \$537.45		
46477	AMPUTATION of 5 DIGITS, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover (Anaes.) (Assist.) Fee: \$731.75 Benefit: 75% = \$548.85 85% = \$674.65		
46480	AMPUTATION of SINGLE DIGIT, proximal to nail bed, involving section of bone or joint and requiring soft tissue cover, including metacarpal (Anaes.) (Assist.) Fee: \$304.95 Benefit: 75% = \$228.75 85% = \$259.25		
46483	REVISION of AMPUTATION STUMP to provide adequate soft tissue cover (Anaes.) (Assist.) Fee: \$243.90 Benefit: 75% = \$182.95 85% = \$207.35		
46486	NAIL BED, accurate reconstruction of nail bed laceration using magnification, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$182.95 Benefit: 75% = \$137.25 85% = \$155.55		

OPERATIONS		ORTHOPAEDIC	
46531	INGROWING NAIL OF FINGER OR THUMB, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) Fee: \$69.00	Benefit: 75% = \$51.75	85% = \$58.65
46534	NAIL PLATE INJURY OR DEFORMITY, radical excision of nail germinal matrix (Anaes.) Fee: \$190.90	Benefit: 75% = \$143.20	85% = \$162.30
SUBGROUP 15 - ORTHOPAEDIC			
TREATMENT OF DISLOCATIONS <i>(Note: See paragraph T8.82 of explanatory notes to this Category)</i>			
47000	MANDIBLE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$57.30	Benefit: 75% = \$43.00	85% = \$48.75
47003	CLAVICLE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$68.70	Benefit: 75% = \$51.55	85% = \$58.40
47006	CLAVICLE, treatment of dislocation of, by open reduction (Anaes.) Fee: \$138.05	Benefit: 75% = \$103.55	85% = \$117.35
47009	SHOULDER, treatment of dislocation of, requiring general anaesthesia, not being a service to which item 47012 applies (Anaes.) Fee: \$137.40	Benefit: 75% = \$103.05	85% = \$116.80
47012	SHOULDER, treatment of dislocation of, requiring general anaesthesia, open reduction (Anaes.) (Assist.) Fee: \$274.80	Benefit: 75% = \$206.10	85% = \$233.60
47015	SHOULDER, treatment of dislocation of, not requiring general anaesthesia Fee: \$68.70	Benefit: 75% = \$51.55	85% = \$58.40
47018	ELBOW, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$160.20	Benefit: 75% = \$120.15	85% = \$136.20
47021	ELBOW, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$213.75	Benefit: 75% = \$160.35	85% = \$181.70
47024	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by closed reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) Fee: \$160.20	Benefit: 75% = \$120.15	85% = \$136.20
47027	RADIOULNAR JOINT, DISTAL or PROXIMAL, treatment of dislocation of, by open reduction, not being a service associated with fracture or dislocation in the same region (Anaes.) (Assist.) Fee: \$213.75	Benefit: 75% = \$160.35	85% = \$181.70
47030	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$160.20	Benefit: 75% = \$120.15	85% = \$136.20
47033	CARPUS, or CARPUS on RADIUS and ULNA, or CARPOMETACARPAL JOINT, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$213.75	Benefit: 75% = \$160.35	85% = \$181.70
47036	INTERPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$68.70	Benefit: 75% = \$51.55	85% = \$58.40
47039	INTERPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) Fee: \$91.55	Benefit: 75% = \$68.70	85% = \$77.85
47042	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$91.55	Benefit: 75% = \$68.70	85% = \$77.85
47045	METACARPOPHALANGEAL JOINT, treatment of dislocation of, by open reduction (Anaes.) Fee: \$122.20	Benefit: 75% = \$91.65	85% = \$103.90
47048	HIP, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$263.35	Benefit: 75% = \$197.55	85% = \$223.85

OPERATIONS		ORTHOPAEDIC
47051	HIP, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47054	KNEE, treatment of dislocation of, by closed reduction (Anaes.) (Assist.) Fee: \$263.35 Benefit: 75% = \$197.55 85% = \$223.85	
47057	PATELLA, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$103.00 Benefit: 75% = \$77.25 85% = \$87.55	
47060	PATELLA, treatment of dislocation of, by open reduction (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47063	ANKLE or TARSUS, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$206.10 Benefit: 75% = \$154.60 85% = \$175.20	
47066	ANKLE or TARSUS, treatment of dislocation of, by open reduction (Anaes.) (Assist.) Fee: \$274.80 Benefit: 75% = \$206.10 85% = \$233.60	
47069	TOE, treatment of dislocation of, by closed reduction (Anaes.) Fee: \$57.30 Benefit: 75% = \$43.00 85% = \$48.75	
47072	TOE, treatment of dislocation of, by open reduction (Anaes.) Fee: \$76.20 Benefit: 75% = \$57.15 85% = \$64.80	
TREATMENT OF FRACTURES		
<i>(Note: See paragraph T8.82 of explanatory notes to this Category)</i>		
47300	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by closed reduction, including percutaneous fixation where used (Anaes.) Fee: \$68.70 Benefit: 75% = \$51.55 85% = \$58.40	
47303	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$80.15 Benefit: 75% = \$60.15 85% = \$68.15	
47306	DISTAL PHALANX of FINGER or THUMB, treatment of fracture of, by open reduction (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47309	DISTAL PHALANX of FINGER or THUMB, treatment of intra-articular fracture of, by open reduction (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40	
47312	MIDDLE PHALANX of FINGER, treatment of fracture of, by closed reduction (Anaes.) Fee: \$103.00 Benefit: 75% = \$77.25 85% = \$87.55	
47315	MIDDLE PHALANX of FINGER, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$118.30 Benefit: 75% = \$88.75 85% = \$100.60	
47318	MIDDLE PHALANX OF FINGER, treatment of fracture of, by open reduction (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47321	MIDDLE PHALANX OF FINGER, treatment of intra-articular fracture of, by open reduction (Anaes.) Fee: \$171.70 Benefit: 75% = \$128.80 85% = \$145.95	
47324	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by closed reduction (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47327	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$160.20 Benefit: 75% = \$120.15 85% = \$136.20	
47330	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of fracture of, by open reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47333	PROXIMAL PHALANX OF FINGER OR THUMB, treatment of intra-articular fracture of, by open operation (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
47336	METACARPAL, treatment of fracture of, by closed reduction (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	

OPERATIONS		ORTHOPAEDIC
47339	METACARPAL, treatment of intra-articular fracture of, by closed reduction (Anaes.) Fee: \$160.20 Benefit: 75% = \$120.15 85% = \$136.20	
47342	METACARPAL, treatment of fracture of, by open reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47345	METACARPAL, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
47348	CARPUS (excluding scaphoid), treatment of fracture of, not being a service to which item 47351 applies (Anaes.) Fee: \$76.20 Benefit: 75% = \$57.15 85% = \$64.80	
47351	CARPUS (excluding scaphoid), treatment of fracture of, by open reduction (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
47354	CARPAL SCAPHOID, treatment of fracture of, not being a service to which item 47357 applies (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47357	CARPAL SCAPHOID, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47360	RADIUS OR ULNA, distal end of, treatment of fracture of, by cast immobilisation, not being a service to which item 47363 or 47366 applies (Anaes.) Fee: \$106.90 Benefit: 75% = \$80.20 85% = \$90.90	
47363	RADIUS OR ULNA, distal end of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$160.20 Benefit: 75% = \$120.15 85% = \$136.20	
47366	RADIUS OR ULNA, distal end of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$213.75 Benefit: 75% = \$160.35 85% = \$181.70	
47369	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by cast immobilisation, not being a service to which item 47372 or 47375 applies (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47372	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture, by closed reduction (Anaes.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
47375	RADIUS, distal end of, treatment of Colles', Smith's or Barton's fracture of, by open reduction (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47378	RADIUS OR ULNA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47381, 47384, 47385 or 47386 applies (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47381	RADIUS OR ULNA, shaft of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$206.10 Benefit: 75% = \$154.60 85% = \$175.20	
47384	RADIUS OR ULNA, shaft of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$274.80 Benefit: 75% = \$206.10 85% = \$233.60	
47385	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) Fee: \$236.60 Benefit: 75% = \$177.45 85% = \$201.15	
47386	RADIUS OR ULNA, shaft of, treatment of fracture of, in conjunction with dislocation of distal radio-ulnar joint or proximal radio-humeral joint (Galeazzi or Monteggia injury), by open reduction or internal fixation (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
47387	RADIUS AND ULNA, shafts of, treatment of fracture of, by cast immobilisation, not being a service to which item 47390 or 47393 applies (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	

OPERATIONS		ORTHOPAEDIC
47390	RADIUS AND ULNA, shafts of, treatment of fracture of, by closed reduction undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$332.05 Benefit: 75% = \$249.05 85% = \$282.25	
47393	RADIUS AND ULNA, shafts of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$442.70 Benefit: 75% = \$332.05 85% = \$385.60	
47396	OLECRANON, treatment of fracture of, not being a service to which item 47399 applies (Anaes.) Fee: \$152.65 Benefit: 75% = \$114.50 85% = \$129.80	
47399	OLECRANON, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47402	OLECRANON, treatment of fracture of, involving excision of olecranon fragment and reimplantation of tendon (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
47405	RADIUS, treatment of fracture of head or neck of, closed management of (Anaes.) Fee: \$152.65 Benefit: 75% = \$114.50 85% = \$129.80	
47408	RADIUS, treatment of fracture of head or neck of, open management of, including internal fixation and excision where performed (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47411	HUMERUS, treatment of fracture of tuberosity of, not being a service to which item 47417 applies (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47414	HUMERUS, treatment of fracture of tuberosity of, by open reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47417	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) Fee: \$213.75 Benefit: 75% = \$160.35 85% = \$181.70	
47420	HUMERUS, treatment of fracture of tuberosity of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$419.85 Benefit: 75% = \$314.90 85% = \$362.75	
47423	HUMERUS, proximal, treatment of fracture of, not being a service to which item 47426, 47429 or 47432 applies (Anaes.) Fee: \$175.50 Benefit: 75% = \$131.65 85% = \$149.20	
47426	HUMERUS, proximal, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$263.35 Benefit: 75% = \$197.55 85% = \$223.85	
47429	HUMERUS, proximal, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47432	HUMERUS, proximal, treatment of intra-articular fracture of, by open reduction (Anaes.) (Assist.) Fee: \$438.90 Benefit: 75% = \$329.20 85% = \$381.80	
47435	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by closed reduction (Anaes.) (Assist.) Fee: \$335.85 Benefit: 75% = \$251.90 85% = \$285.50	
47438	HUMERUS, proximal, treatment of fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$534.40 Benefit: 75% = \$400.80 85% = \$477.30	
47441	HUMERUS, proximal, treatment of intra-articular fracture of, and associated dislocation of shoulder, by open reduction (Anaes.) (Assist.) Fee: \$667.90 Benefit: 75% = \$500.95 85% = \$610.80	
47444	HUMERUS, shaft of, treatment of fracture of, not being a service to which item 47447 or 47450 applies (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47447	HUMERUS, shaft of, treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$274.80 Benefit: 75% = \$206.10 85% = \$233.60	
47450	HUMERUS, shaft of, treatment of fracture of, by internal or external fixation (Anaes.) (Assist.) Fee: \$366.40 Benefit: 75% = \$274.80 85% = \$311.45	

OPERATIONS		ORTHOPAEDIC
47451	HUMERUS, shaft of, treatment of fracture of, by intramedullary fixation (Anaes.) (Assist.) Fee: \$441.70 Benefit: 75% = \$331.30 85% = \$384.60	
47453	HUMERUS, distal, (supracondylar or condylar), treatment of fracture of, not being a service to which item 47456 or 47459 applies (Anaes.) (Assist.) Fee: \$213.75 Benefit: 75% = \$160.35 85% = \$181.70	
47456	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by closed reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$320.70 Benefit: 75% = \$240.55 85% = \$272.60	
47459	HUMERUS, distal (supracondylar or condylar), treatment of fracture of, by open reduction, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) Fee: \$427.45 Benefit: 75% = \$320.60 85% = \$370.35	
47462	CLAVICLE, treatment of fracture of, not being a service to which item 47465 applies (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47465	CLAVICLE, treatment of fracture of, by open reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47466	STERNUM, treatment of fracture of, not being a service to which item 47467 applies (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47467	STERNUM, treatment of fracture of, by open reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47468	SCAPULA, neck or glenoid region of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47471	RIBS (1 or more), treatment of fracture of - each attendance Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60	
47474	PELVIC RING, treatment of fracture of, not involving disruption of pelvic ring or acetabulum Fee: \$152.65 Benefit: 75% = \$114.50 85% = \$129.80	
47477	PELVIC RING, treatment of fracture of, with disruption of pelvic ring or acetabulum Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
47480	PELVIC RING, treatment of fracture of, requiring traction (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
47483	PELVIC RING, treatment of fracture of, requiring control by external fixation (Anaes.) (Assist.) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85	
47486	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of anterior segment, including diastasis of pubic symphysis (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
47489	PELVIC RING, treatment of fracture of, by open reduction and involving internal fixation of posterior segment (including sacro-iliac joint), with or without fixation of anterior segment (Anaes.) (Assist.) Fee: \$1,145.00 Benefit: 75% = \$858.75 85% = \$1,087.90	
47492	ACETABULUM, treatment of fracture of, and associated dislocation of hip (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
47495	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring traction (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
47498	ACETABULUM, treatment of fracture of, and associated dislocation of hip, requiring internal fixation, with or without traction (Anaes.) (Assist.) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35	
47501	ACETABULUM, treatment of single column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	

OPERATIONS		ORTHOPAEDIC
47504	ACETABULUM, treatment of T-shape fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) Fee: \$1,145.00 Benefit: 75% = \$858.75 85% = \$1,087.90	
47507	ACETABULUM, treatment of transverse fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) Fee: \$1,145.00 Benefit: 75% = \$858.75 85% = \$1,087.90	
47510	ACETABULUM, treatment of double column fracture of, by open reduction and internal fixation, including any osteotomy, osteectomy or capsulotomy required for exposure and subsequent repair (Anaes.) (Assist.) Fee: \$1,145.00 Benefit: 75% = \$858.75 85% = \$1,087.90	
47513	SACRO-ILIAC JOINT DISRUPTION, treatment of, requiring internal fixation, being a service associated with a service to which items 47501 to 47510 apply (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47516	FEMUR, treatment of fracture of, by closed reduction or traction (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47519	FEMUR, treatment of trochanteric or subcapital fracture of, by internal fixation (Anaes.) (Assist.) Fee: \$702.30 Benefit: 75% = \$526.75 85% = \$645.20	
47522	FEMUR, treatment of subcapital fracture of, by hemi-arthroplasty (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
47525	FEMUR, treatment of fracture of, for slipped capital femoral epiphysis (Anaes.) (Assist.) Fee: \$702.30 Benefit: 75% = \$526.75 85% = \$645.20	
47528	FEMUR, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
47531	FEMUR, treatment of fracture of shaft, by intramedullary fixation and cross fixation (Anaes.) (Assist.) Fee: \$778.55 Benefit: 75% = \$583.95 85% = \$721.45	
47534	FEMUR, condylar region of, treatment of intra-articular (T-shaped condylar) fracture of, requiring internal fixation, with or without internal fixation of 1 or more osteochondral fragments (Anaes.) (Assist.) Fee: \$877.80 Benefit: 75% = \$658.35 85% = \$820.70	
47537	FEMUR, condylar region of, treatment of fracture of, requiring internal fixation of 1 or more osteochondral fragments, not being a service associated with a service to which item 47534 applies (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47540	HIP SPICA OR SHOULDER SPICA, application of, as an independent procedure (Anaes.) Fee: \$175.50 Benefit: 75% = \$131.65 85% = \$149.20	
47543	TIBIA, plateau of, treatment of medial or lateral fracture of, not being a service to which item 47546 or 47549 applies (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47546	TIBIA, plateau of, treatment of medial or lateral fracture of, by closed reduction (Anaes.) Fee: \$274.80 Benefit: 75% = \$206.10 85% = \$233.60	
47549	TIBIA, plateau of, treatment of medial or lateral fracture of, by open reduction (Anaes.) (Assist.) Fee: \$366.40 Benefit: 75% = \$274.80 85% = \$311.45	
47552	TIBIA, plateau of, treatment of both medial and lateral fractures of, not being a service to which item 47555 or 47558 applies (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47555	TIBIA, plateau of, treatment of both medial and lateral fractures of, by closed reduction (Anaes.) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85	
47558	TIBIA, plateau of, treatment of both medial and lateral fractures of, by open reduction (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
47561	TIBIA, shaft of, treatment of fracture of, by cast immobilisation, not being a service to which item 47564 , 47567 , 47570 or 47573 applies (Anaes.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	

OPERATIONS		ORTHOPAEDIC
47564	TIBIA, shaft of, treatment of fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) Fee: \$332.05 Benefit: 75% = \$249.05 85% = \$282.25	
47565	TIBIA, shaft of, treatment of fracture of, by internal fixation or external fixation (Anaes.) (Assist.) Fee: \$577.55 Benefit: 75% = \$433.20 85% = \$520.45	
47566	TIBIA, shaft of, treatment of fracture of, by intramedullary fixation and cross fixation (Anaes.) (Assist.) Fee: \$736.25 Benefit: 75% = \$552.20 85% = \$679.15	
47567	TIBIA, shaft of, treatment of intra-articular fracture of, by closed reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) Fee: \$385.40 Benefit: 75% = \$289.05 85% = \$328.30	
47570	TIBIA, shaft of, treatment of fracture of, by open reduction, with or without treatment of fibular fracture (Anaes.) (Assist.) Fee: \$442.70 Benefit: 75% = \$332.05 85% = \$385.60	
47573	TIBIA, shaft of, treatment of intra-articular fracture of, by open reduction, with or without treatment of fibula fracture (Anaes.) (Assist.) Fee: \$553.35 Benefit: 75% = \$415.05 85% = \$496.25	
47576	FIBULA, treatment of fracture of (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47579	PATELLA, treatment of fracture of, not being a service to which item 47582 or 47585 applies (Anaes.) Fee: \$129.80 Benefit: 75% = \$97.35 85% = \$110.35	
47582	PATELLA, treatment of fracture of, by excision of patella or pole with reattachment of tendon (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15	
47585	PATELLA, treatment of fracture of, by internal fixation (Anaes.) (Assist.) Fee: \$343.55 Benefit: 75% = \$257.70 85% = \$292.05	
47588	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar or tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	
47591	KNEE JOINT, treatment of fracture of, by internal fixation of intra-articular fractures of femoral condylar and tibial articular surfaces and requiring repair or reconstruction of 1 or more ligaments (Anaes.) (Assist.) Fee: \$1,297.75 Benefit: 75% = \$973.35 85% = \$1,240.65	
47594	ANKLE JOINT, treatment of fracture of, not being a service to which item 47597 applies (Anaes.) Fee: \$175.50 Benefit: 75% = \$131.65 85% = \$149.20	
47597	ANKLE JOINT, treatment of fracture of, by closed reduction (Anaes.) Fee: \$263.35 Benefit: 75% = \$197.55 85% = \$223.85	
47600	ANKLE JOINT, treatment of fracture of, by internal fixation of 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47603	ANKLE JOINT, treatment of fracture of, by internal fixation of more than 1 of malleolus, fibula or diastasis (Anaes.) (Assist.) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85	
47606	CALCANEUM OR TALUS, treatment of fracture of, not being a service to which item 47609, 47612, 47615 or 47618 applies, with or without dislocation (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
47609	CALCANEUM OR TALUS, treatment of fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$286.25 Benefit: 75% = \$214.70 85% = \$243.35	
47612	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$332.05 Benefit: 75% = \$249.05 85% = \$282.25	
47615	CALCANEUM OR TALUS, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	

OPERATIONS		ORTHOPAEDIC
47618	CALCANEUM OR TALUS, treatment of intra-articular fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$477.15 Benefit: 75% = \$357.90 85% = \$420.05	
47621	TARSO-METATARSAL, treatment of intra-articular fracture of, by closed reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$332.05 Benefit: 75% = \$249.05 85% = \$282.25	
47624	TARSO-METATARSAL, treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85	
47627	TARSUS (excluding calcaneum or talus), treatment of fracture of (Anaes.) Fee: \$129.80 Benefit: 75% = \$97.35 85% = \$110.35	
47630	TARSUS (excluding calcaneum or talus), treatment of fracture of, by open reduction, with or without dislocation (Anaes.) (Assist.) Fee: \$274.80 Benefit: 75% = \$206.10 85% = \$233.60	
47633	METATARSAL, 1 of, treatment of fracture of (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47636	METATARSAL, 1 of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47639	METATARSAL, 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47642	METATARSALS, 2 of, treatment of fracture of (Anaes.) Fee: \$122.20 Benefit: 75% = \$91.65 85% = \$103.90	
47645	METATARSALS, 2 of, treatment of fracture of, by closed reduction (Anaes.) Fee: \$183.20 Benefit: 75% = \$137.40 85% = \$155.75	
47648	METATARSALS, 2 of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$244.15 Benefit: 75% = \$183.15 85% = \$207.55	
47651	METATARSALS, 3 or more of, treatment of fracture of (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
47654	METATARSALS, 3 or more of, treatment of fracture of, by closed reduction (Anaes.) (Assist.) Fee: \$286.25 Benefit: 75% = \$214.70 85% = \$243.35	
47657	METATARSALS, 3 or more of, treatment of fracture of, by open reduction (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
47663	PHALANX OF GREAT TOE, treatment of fracture of, by closed reduction (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40	
47666	PHALANX OF GREAT TOE, treatment of fracture of, by open reduction (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
47672	PHALANX OF TOE (other than great toe), 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47678	PHALANX OF TOE (other than great toe), more than 1 of, treatment of fracture of, by open reduction (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
47681	SPINE (excluding sacrum), treatment of fracture of transverse process, vertebral body, or posterior elements - each attendance Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60	
47684	SPINE, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, including immobilisation by calipers (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
47687	SPINE, treatment of fracture, dislocation or fracture-dislocation, with spinal cord involvement, including immobilisation by calipers, and including up to 14 days post-operative care (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	

OPERATIONS		ORTHOPAEDIC	
47690	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation (Anaes.) (Assist.) Fee: \$839.65 Benefit: 75% = \$629.75 85% = \$782.55		
47693	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, including immobilisation by calipers, requiring reduction by closed manipulation, including up to 14 days post-operative care (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45		
47696	SPINE, reduction of fracture or dislocation of, without cord involvement, undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55		
47699	SPINE, treatment of fracture, dislocation or fracture-dislocation, without cord involvement, requiring open reduction with or without internal fixation (Anaes.) (Assist.) Fee: \$1,221.30 Benefit: 75% = \$916.00 85% = \$1,164.20		
47702	SPINE, treatment of fracture, dislocation or fracture-dislocation, with cord involvement, requiring open reduction with or without internal fixation, including up to 14 days post-operative care (Anaes.) (Assist.) Fee: \$1,526.70 Benefit: 75% = \$1,145.05 85% = \$1,469.60		
47703	SKULL, treatment of fracture of, each attendance Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60		
47705	SKULL CALIPERS, insertion of, as an independent procedure (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60		
47708	PLASTER JACKET, application of, as an independent procedure (Anaes.) Fee: \$175.50 Benefit: 75% = \$131.65 85% = \$149.20		
47711	HALO, application of, as an independent procedure (Anaes.) (Assist.) Fee: \$259.60 Benefit: 75% = \$194.70 85% = \$220.70		
47714	HALO, application of, in addition to spinal fusion for scoliosis, or other conditions (Anaes.) Fee: \$194.65 Benefit: 75% = \$146.00 85% = \$165.50		
47717	HALO-THORACIC TRACTION - application of both halo and thoracic jacket (Anaes.) (Assist.) Fee: \$343.55 Benefit: 75% = \$257.70 85% = \$292.05		
47720	HALO-FEMORAL TRACTION, as an independent procedure (Anaes.) (Assist.) Fee: \$343.55 Benefit: 75% = \$257.70 85% = \$292.05		
47723	HALO-FEMORAL TRACTION, in conjunction with a major spine operation (Anaes.) (Assist.) Fee: \$343.55 Benefit: 75% = \$257.70 85% = \$292.05		
47726	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - small quantity (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40		
47729	BONE GRAFT, harvesting of, via separate incision, in conjunction with another service - autogenous - large quantity (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30		
47732	VASCULARISED PEDICLE BONE GRAFT, harvesting of, in conjunction with another service (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55		
47735	NASAL BONES, treatment of fracture of, not being a service to which item 47738 or 47741 applies - each attendance Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60		
47738	NASAL BONES, treatment of fracture of, by reduction (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30		
47741	NASAL BONES, treatment of fracture of, by open reduction involving osteotomies (Anaes.) (Assist.) Fee: \$389.40 Benefit: 75% = \$292.05 85% = \$332.30		
47753	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) Fee: \$329.70 Benefit: 75% = \$247.30 85% = \$280.25		

OPERATIONS		ORTHOPAEDIC	
47756	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) Fee: \$329.70	Benefit: 75% = \$247.30	85% = \$280.25
47762	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) Fee: \$193.65	Benefit: 75% = \$145.25	85% = \$164.65
47765	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) Fee: \$317.90	Benefit: 75% = \$238.45	85% = \$270.25
47768	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) Fee: \$389.40	Benefit: 75% = \$292.05	85% = \$332.30
47771	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) Fee: \$447.35	Benefit: 75% = \$335.55	85% = \$390.25
47774	MAXILLA, treatment of fracture of, requiring open operation (Anaes.) (Assist.) Fee: \$353.25	Benefit: 75% = \$264.95	85% = \$300.30
47777	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) Fee: \$353.25	Benefit: 75% = \$264.95	85% = \$300.30
47780	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) Fee: \$459.15	Benefit: 75% = \$344.40	85% = \$402.05
47783	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) Fee: \$459.15	Benefit: 75% = \$344.40	85% = \$402.05
47786	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) Fee: \$582.75	Benefit: 75% = \$437.10	85% = \$525.65
47789	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) Fee: \$582.75	Benefit: 75% = \$437.10	85% = \$525.65
GENERAL			
47900	BONE CYST, injection into or aspiration of (Anaes.) Fee: \$137.40	Benefit: 75% = \$103.05	85% = \$116.80
47903	EPICONDYLITIS, open operation for (Anaes.) Fee: \$190.90	Benefit: 75% = \$143.20	85% = \$162.30
47904	DIGITAL NAIL OF TOE, removal of, not being a service to which item 47906 applies (Anaes.) Fee: \$45.80	Benefit: 75% = \$34.35	85% = \$38.95
47906	DIGITAL NAIL OF TOE, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$91.55	Benefit: 75% = \$68.70	85% = \$77.85
47912	PULP SPACE INFECTION, PARONYCHIA of FOOT, incision for, not being a service to which another item in this Group applies (excluding aftercare) (Anaes.) Fee: \$45.80	Benefit: 75% = \$34.35	85% = \$38.95
47915	INGROWING NAIL OF TOE, wedge resection for, including removal of segment of nail, unguis fold and portion of the nail bed (Anaes.) Fee: \$137.40	Benefit: 75% = \$103.05	85% = \$116.80
47916	INGROWING NAIL OF TOE, partial resection of nail, including phenolisation but not including excision of nail bed (Anaes.) Fee: \$69.00	Benefit: 75% = \$51.75	85% = \$58.65
47918	INGROWING TOENAIL, radical excision of nailbed (Anaes.) Fee: \$190.90	Benefit: 75% = \$143.20	85% = \$162.30
47920	BONE GROWTH STIMULATOR, insertion of (Anaes.) (Assist.) Fee: \$308.75	Benefit: 75% = \$231.60	85% = \$262.45

OPERATIONS		ORTHOPAEDIC
47921	ORTHOPAEDIC PIN OR WIRE, insertion of, as an independent procedure (Anaes.) Fee: \$91.55 Benefit: 75% = \$68.70 85% = \$77.85	
47924	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of requiring incision and suture, not being a service to which item 47927 or 47930 applies - per bone (Anaes.) Fee: \$30.50 Benefit: 75% = \$22.90 85% = \$25.95	
47927	BURIED WIRE, PIN OR SCREW, 1 or more of, which were inserted for internal fixation purposes, removal of, in the operating theatre of a hospital or approved day-hospital facility - per bone (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40	
47930	PLATE, ROD OR NAIL AND ASSOCIATED WIRES, PINS OR SCREWS, 1 or more of, all of which were inserted for internal fixation purposes, <u>removal of</u> , not being a service associated with a service to which item 47924 or 47927 applies - per bone (Anaes.) (Assist.) Fee: \$213.75 Benefit: 75% = \$160.35 85% = \$181.70	
47933	EXOSTOSIS OF SMALL BONE, excision of, including simple removal of bunion and any associated bursa (Anaes.) Fee: \$167.90 Benefit: 75% = \$125.95 85% = \$142.75	
47936	EXOSTOSIS OF LARGE BONE, excision of (Anaes.) (Assist.) Fee: \$206.10 Benefit: 75% = \$154.60 85% = \$175.20	
47948	EXTERNAL FIXATION, removal of, in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$129.80 Benefit: 75% = \$97.35 85% = \$110.35	
47951	EXTERNAL FIXATION, removal of, in conjunction with operations involving internal fixation or bone grafting or both (Anaes.) Fee: \$152.65 Benefit: 75% = \$114.50 85% = \$129.80	
47954	TENDON, repair of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
47957	TENDON, large, lengthening of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
47960	TENOTOMY, SUBCUTANEOUS, not being a service to which another item in this Group applies (Anaes.) Fee: \$106.90 Benefit: 75% = \$80.20 85% = \$90.90	
47963	TENOTOMY, OPEN, with or without tenoplasty, not being a service to which another item in this Group applies (Anaes.) Fee: \$175.50 Benefit: 75% = \$131.65 85% = \$149.20	
47966	TENDON OR LIGAMENT, TRANSFER, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
47969	TENOSYNOVECTOMY, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$213.75 Benefit: 75% = \$160.35 85% = \$181.70	
47972	TENDON SHEATH, open operation for teno-vaginitis, not being a service to which another item in this Group applies (Anaes.) Fee: \$170.75 Benefit: 75% = \$128.10 85% = \$145.15	
47975	FOREARM OR CALF, decompression fasciotomy of, for acute compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) (Assist.) Fee: \$299.25 Benefit: 75% = \$224.45 85% = \$254.40	
47978	FOREARM OR CALF, decompression fasciotomy of, for chronic compartment syndrome, requiring excision of muscle and deep tissue (Anaes.) Fee: \$181.80 Benefit: 75% = \$136.35 85% = \$154.55	
47981	FOREARM, CALF OR INTEROSSEOUS MUSCLE SPACE OF HAND, decompression fasciotomy of, not being a service to which another item applies (Anaes.) Fee: \$122.00 Benefit: 75% = \$91.50 85% = \$103.70	
47982	FORAGE (Drill decompression), of NECK OR HEAD of FEMUR, or BOTH (Anaes.) (Assist.) Fee: \$295.85 Benefit: 75% = \$221.90 85% = \$251.50	

OPERATIONS		ORTHOPAEDIC	
BONE GRAFTS			
48200	FEMUR, bone graft to (Anaes.) (Assist.) Fee: \$610.70	Benefit: 75% = \$458.05	85% = \$553.60
48203	FEMUR, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$740.45	Benefit: 75% = \$555.35	85% = \$683.35
48206	TIBIA, bone graft to (Anaes.) (Assist.) Fee: \$458.45	Benefit: 75% = \$343.85	85% = \$401.35
48209	TIBIA, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$587.75	Benefit: 75% = \$440.85	85% = \$530.65
48212	HUMERUS, bone graft to (Anaes.) (Assist.) Fee: \$458.45	Benefit: 75% = \$343.85	85% = \$401.35
48215	HUMERUS, bone graft to, with internal fixation (Anaes.) (Assist.) Fee: \$587.75	Benefit: 75% = \$440.85	85% = \$530.65
48218	RADIUS AND ULNA, bone graft to (Anaes.) (Assist.) Fee: \$458.45	Benefit: 75% = \$343.85	85% = \$401.35
48221	RADIUS AND ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) Fee: \$610.70	Benefit: 75% = \$458.05	85% = \$553.60
48224	RADIUS OR ULNA, bone graft to (Anaes.) (Assist.) Fee: \$305.35	Benefit: 75% = \$229.05	85% = \$259.55
48227	RADIUS OR ULNA, bone graft to, with internal fixation of 1 or both bones (Anaes.) (Assist.) Fee: \$396.95	Benefit: 75% = \$297.75	85% = \$339.85
48230	SCAPHOID, bone graft to, for non-union (Anaes.) (Assist.) Fee: \$343.55	Benefit: 75% = \$257.70	85% = \$292.05
48233	SCAPHOID, bone graft to, for non-union, with internal fixation (Anaes.) (Assist.) Fee: \$496.15	Benefit: 75% = \$372.15	85% = \$439.05
48236	SCAPHOID, bone graft to, for mal-union, including osteotomy, bone graft and internal fixation (Anaes.) (Assist.) Fee: \$648.85	Benefit: 75% = \$486.65	85% = \$591.75
48239	BONE GRAFT, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$358.75	Benefit: 75% = \$269.10	85% = \$304.95
48242	BONE GRAFT, with internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$496.15	Benefit: 75% = \$372.15	85% = \$439.05
OSTEOTOMY OR OSTEECTOMY			
48400	PHALANX, METATARSAL, ACCESSORY BONE OR SESAMOID BONE, osteotomy or osteectomy of, excluding services to which item 49848 or 49851 applies (Anaes.) (Assist.) Fee: \$267.20	Benefit: 75% = \$200.40	85% = \$227.15
48403	PHALANX OR METATARSAL, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$419.85	Benefit: 75% = \$314.90	85% = \$362.75
48406	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$267.20	Benefit: 75% = \$200.40	85% = \$227.15
48409	FIBULA, RADIUS, ULNA, CLAVICLE, SCAPULA (other than Acromion), RIB, TARSUS OR CARPUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$419.85	Benefit: 75% = \$314.90	85% = \$362.75
48412	HUMERUS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$511.30	Benefit: 75% = \$383.50	85% = \$454.20

OPERATIONS		ORTHOPAEDIC
48415	HUMERUS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$648.85 Benefit: 75% = \$486.65 85% = \$591.75	
48418	TIBIA, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$511.30 Benefit: 75% = \$383.50 85% = \$454.20	
48421	TIBIA, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$648.85 Benefit: 75% = \$486.65 85% = \$591.75	
48424	FEMUR OR PELVIS, osteotomy or osteectomy of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
48427	FEMUR OR PELVIS, osteotomy or osteectomy of, with internal fixation (Anaes.) (Assist.) Fee: \$740.45 Benefit: 75% = \$555.35 85% = \$683.35	
EPIPHYSIODESIS		
48500	FEMUR, epiphysiodesis of (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15	
48503	TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15	
48506	FEMUR, TIBIA AND FIBULA, epiphysiodesis of (Anaes.) (Assist.) Fee: \$396.95 Benefit: 75% = \$297.75 85% = \$339.85	
48509	EPIPHYSIODESIS, staple arrest of hemiepiphysis (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
48512	EPIPHYSIOLYSIS, operation to prevent closure of plate (Anaes.) (Assist.) Fee: \$725.10 Benefit: 75% = \$543.85 85% = \$668.00	
SPINE		
48600	SPINE, MANIPULATION OF, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$76.20 Benefit: 75% = \$57.15 85% = \$64.80	
48603	SPINE, manipulation of, under epidural anaesthesia, with or without steroid injection, where the manipulation and the administration of the epidural anaesthetic are performed by the same medical practitioner in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which item 48600 or 50115 applies (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40	
48606	SCOLIOSIS or KYPHOSIS, spinal fusion for (without instrumentation) (Anaes.) (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	
48609	SCOLIOSIS or KYPHOSIS, spinal fusion for, using Harrington or other nonsegmental fixation (Anaes.) (Assist.) Fee: \$1,335.80 Benefit: 75% = \$1,001.85 85% = \$1,278.70	
48612	SCOLIOSIS, spinal fusion for, using segmental instrumentation (C D, Zielke, Luque, or similar) (Anaes.) (Assist.) Fee: \$1,984.65 Benefit: 75% = \$1,488.50 85% = \$1,927.55	
48613	SCOLIOSIS OR KYPHOSIS, spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) Fee: \$2,822.95 Benefit: 75% = \$2,117.25 85% = \$2,765.85	
48615	SCOLIOSIS, re-exploration for, involving adjustment or removal of instrumentation or simple bone grafting procedure (Anaes.) (Assist.) Fee: \$358.75 Benefit: 75% = \$269.10 85% = \$304.95	
48618	SCOLIOSIS, revision of failed scoliosis surgery, involving more than 1 of multiple osteotomy, fusion or instrumentation (Anaes.) (Assist.) Fee: \$1,984.65 Benefit: 75% = \$1,488.50 85% = \$1,927.55	
48621	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke, or similar) - not more than 4 levels (Anaes.) (Assist.) Fee: \$1,297.75 Benefit: 75% = \$973.35 85% = \$1,240.65	

OPERATIONS		ORTHOPAEDIC	
48624	SCOLIOSIS, anterior correction of, with fusion and segmental fixation (Dwyer, Zielke or similar) - more than 4 levels (Anaes.) (Assist.) Fee: \$1,603.05	Benefit: 75% = \$1,202.30	85% = \$1,545.95
48627	SCOLIOSIS, spinal fusion for, combined with segmental instrumentation (C D, Zielke or similar) down to and including pelvis (Anaes.) (Assist.) Fee: \$2,060.90	Benefit: 75% = \$1,545.70	85% = \$2,003.80
48630	SCOLIOSIS, requiring anterior decompression of spinal cord with resection of vertebrae including bone graft and instrumentation in the presence of spinal cord involvement (Anaes.) (Assist.) Fee: \$2,289.90	Benefit: 75% = \$1,717.45	85% = \$2,232.80
48632	SCOLIOSIS, congenital, vertebral resection and fusion for (Anaes.) (Assist.) Fee: \$1,265.80	Benefit: 75% = \$949.35	85% = \$1,208.70
48636	PERCUTANEOUS LUMBAR DISCECTOMY, 1 or more levels (Anaes.) (Assist.) Fee: \$656.35	Benefit: 75% = \$492.30	85% = \$599.25
48639	VERTEBRAL BODY, total or subtotal excision of, including bone grafting or other form of fixation (Anaes.) (Assist.) Fee: \$1,106.80	Benefit: 75% = \$830.10	85% = \$1,049.70
48640	VERTEBRAL BODY, disease of, excision and spinal fusion for, using segmental instrumentation, reconstruction utilising separate anterior and posterior approaches (Anaes.) (Assist.) Fee: \$2,822.95	Benefit: 75% = \$2,117.25	85% = \$2,765.85
48642	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - 1 or 2 levels (Anaes.) (Assist.) Fee: \$648.85	Benefit: 75% = \$486.65	85% = \$591.75
48645	SPINE, posterior, bone graft to, not being a service to which item 48648 or 48651 applies - more than 2 levels (Anaes.) (Assist.) Fee: \$877.80	Benefit: 75% = \$658.35	85% = \$820.70
48648	SPINE, bone graft to, (postero-lateral fusion) - 1 or 2 levels (Anaes.) (Assist.) Fee: \$877.80	Benefit: 75% = \$658.35	85% = \$820.70
48651	SPINE, bone graft to, (postero-lateral fusion) - more than 2 levels (Anaes.) (Assist.) Fee: \$1,221.30	Benefit: 75% = \$916.00	85% = \$1,164.20
48654	SPINAL FUSION (posterior interbody), with laminectomy, 1 level (Anaes.) (Assist.) Fee: \$877.80	Benefit: 75% = \$658.35	85% = \$820.70
48657	SPINAL FUSION (posterior interbody), with laminectomy, more than 1 level (Anaes.) (Assist.) Fee: \$1,221.30	Benefit: 75% = \$916.00	85% = \$1,164.20
48660	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (Anaes.) (Assist.) Fee: \$877.80	Benefit: 75% = \$658.35	85% = \$820.70
48663	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) Fee: \$656.35	Benefit: 75% = \$492.30	85% = \$599.25
48666	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) Fee: \$396.95	Benefit: 75% = \$297.75	85% = \$339.85
48669	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (Anaes.) (Assist.) Fee: \$1,183.15	Benefit: 75% = \$887.40	85% = \$1,126.05
48672	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - principal surgeon (Anaes.) (Assist.) Fee: \$885.55	Benefit: 75% = \$664.20	85% = \$828.45
48675	SPINAL FUSION (anterior interbody) to cervical, thoracic or lumbar regions - more than 1 level (where an assisting surgeon performs the approach) - assisting surgeon (Assist.) Fee: \$534.40	Benefit: 75% = \$400.80	85% = \$477.30

OPERATIONS		ORTHOPAEDIC	
48678	SPINE, simple internal fixation of, involving 1 or more of facet screw, wire loop or similar, being a service associated with a service to which items 48642 to 48675 apply (Anaes.) (Assist.) (See para T8.83 of explanatory notes to this Category) Fee: \$458.45 Benefit: 75% = \$343.85 85% = \$401.35		
48681	SPINE, non-segmental internal fixation of (Harrington or similar), other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies (Anaes.) (Assist.) (See para T8.83 of explanatory notes to this Category) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20		
48684	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which any one of items 48642 to 48675 applies - 1 or 2 levels (Anaes.) (Assist.) (See para T8.83 of explanatory notes to this Category) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20		
48687	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - 3 or 4 levels (Anaes.) (Assist.) (See para T8.83 of explanatory notes to this Category) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45		
48690	SPINE, segmental internal fixation of, other than for scoliosis, being a service associated with a service to which items 48642 to 48675 apply - more than 4 levels (Anaes.) (Assist.) (See para T8.83 of explanatory notes to this Category) Fee: \$1,221.30 Benefit: 75% = \$916.00 85% = \$1,164.20		
SHOULDER			
48900	SHOULDER, excision of coraco-acromial ligament or removal of calcium deposit from cuff or both (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60		
48903	SHOULDER, decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination (Anaes.) (Assist.) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85		
48906	SHOULDER, repair of rotator cuff, including excision of coraco-acromial ligament or removal of calcium deposit from cuff, or both - not being a service associated with a service to which item 48900 applies (Anaes.) (Assist.) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85		
48909	SHOULDER, repair of rotator cuff, including decompression of subacromial space by acromioplasty, excision of coraco-acromial ligament and distal clavicle, or any combination, not being a service associated with a service to which item 48903 applies (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60		
48912	SHOULDER, arthrotomy of (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15		
48915	SHOULDER, hemi-arthroplasty of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60		
48918	SHOULDER, total replacement arthroplasty of, including any associated rotator cuff repair (Anaes.) (Assist.) Fee: \$1,221.30 Benefit: 75% = \$916.00 85% = \$1,164.20		
48921	SHOULDER, total replacement arthroplasty, revision of (Anaes.) (Assist.) Fee: \$1,259.45 Benefit: 75% = \$944.60 85% = \$1,202.35		
48924	SHOULDER, total replacement arthroplasty, revision of, requiring bone graft to scapula or humerus, or both (Anaes.) (Assist.) Fee: \$1,450.40 Benefit: 75% = \$1,087.80 85% = \$1,393.30		
48927	SHOULDER prosthesis, removal of (Anaes.) (Assist.) Fee: \$297.60 Benefit: 75% = \$223.20 85% = \$253.00		
48930	SHOULDER, stabilisation procedure for recurrent anterior or posterior dislocation (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60		
48933	SHOULDER, stabilisation procedure for multi-directional instability, including anterior or posterior (or both) repair when performed (Anaes.) (Assist.) Fee: \$801.50 Benefit: 75% = \$601.15 85% = \$744.40		

OPERATIONS		ORTHOPAEDIC
48936	SHOULDER, synovectomy of, as an independent procedure (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
48939	SHOULDER, arthrodesis of (Anaes.) (Assist.) Fee: \$877.80 Benefit: 75% = \$658.35 85% = \$820.70	
48942	SHOULDER, arthrodesis of, including removal of prosthesis, requiring bone grafting or internal fixation (Anaes.) (Assist.) Fee: \$1,145.00 Benefit: 75% = \$858.75 85% = \$1,087.90	
48945	SHOULDER, diagnostic arthroscopy of (including biopsy) - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	
48948	SHOULDER, arthroscopic surgery of, involving any 1 or more of: removal of loose bodies; decompression of calcium deposit; debridement of labrum, synovium or rotator cuff; or chondroplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	
48951	SHOULDER, arthroscopic division of coraco-acromial ligament including acromioplasty - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$725.10 Benefit: 75% = \$543.85 85% = \$668.00	
48954	SHOULDER, arthroscopic total synovectomy of, including release of contracture when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
48957	SHOULDER, arthroscopic stabilisation of, for recurrent instability including labral repair or reattachment when performed - not being a service associated with any other arthroscopic procedure of the shoulder region (Anaes.) (Assist.) Fee: \$877.80 Benefit: 75% = \$658.35 85% = \$820.70	
48960	SHOULDER, reconstruction or repair of, including repair of rotator cuff by arthroscopic, arthroscopic assisted or mini open means; arthroscopic acromioplasty; or resection of acromioclavicular joint by separate approach when performed - not being a service associated with any other procedure of the shoulder region (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
ELBOW		
49100	ELBOW, arthrotomy of, involving 1 or more of lavage, removal of loose body or division of contracture (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15	
49103	ELBOW, ligamentous stabilisation of (Anaes.) (Assist.) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35	
49106	ELBOW, arthrodesis of (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
49109	ELBOW, total synovectomy of (Anaes.) (Assist.) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35	
49112	ELBOW, silastic or other replacement of radial head (Anaes.) (Assist.) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35	
49115	ELBOW, total joint replacement of (Anaes.) (Assist.) Fee: \$915.95 Benefit: 75% = \$687.00 85% = \$858.85	
49118	ELBOW, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	
49121	ELBOW, arthroscopic surgery involving any 1 or more of: drilling of defect, removal of loose body; release of contracture or adhesions; chondroplasty; or osteoplasty - not being a service associated with any other arthroscopic procedure of the elbow (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	

OPERATIONS		ORTHOPAEDIC
WRIST		
49200	WRIST, arthrodesis of, including bone graft, with or without internal fixation of the radiocarpal joint (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$664.00 Benefit: 75% = \$498.00 85% = \$606.90	
49203	WRIST, limited arthrodesis of the intercarpal joint, including bone graft (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	
49206	WRIST, proximal carpectomy of, including styloidectomy when performed (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$457.95 Benefit: 75% = \$343.50 85% = \$400.85	
49209	WRIST, total replacement arthroplasty of (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
49212	WRIST, arthrotomy of (Anaes.) (See para T8.84 of explanatory notes to this Category) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
49215	WRIST, reconstruction of, including repair of single or multiple ligaments or capsules, including associated arthrotomy (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$526.75 Benefit: 75% = \$395.10 85% = \$469.65	
49218	WRIST, diagnostic arthroscopy of, including radiocarpal or midcarpal joints, or both (including biopsy) - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	
49221	WRIST, arthroscopic surgery of, involving any 1 or more of: drilling of defect; removal of loose body; release of adhesions; local synovectomy; or debridement of one area - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	
49224	WRIST, arthroscopic debridement of 2 or more distinct areas; or osteoplasty including excision of the distal ulna; or total synovectomy (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35	
49227	WRIST, arthroscopic pinning of osteochondral fragment or stabilisation procedure for ligamentous disruption - not being a service associated with any other arthroscopic procedure of the wrist joint (Anaes.) (Assist.) (See para T8.84 of explanatory notes to this Category) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35	
HIP		
49300	SACROILIAC JOINT arthrodesis of (Anaes.) (Assist.) Fee: \$422.60 Benefit: 75% = \$316.95 85% = \$365.50	
49303	HIP, arthrotomy of, including lavage, drainage or biopsy when performed (Anaes.) (Assist.) Fee: \$442.70 Benefit: 75% = \$332.05 85% = \$385.60	
49306	HIP arthrodesis of (Anaes.) (Assist.) Fee: \$877.80 Benefit: 75% = \$658.35 85% = \$820.70	
49309	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (Austin Moore or similar (non cement)) (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
49312	HIP, arthrectomy or excision arthroplasty of, including removal of prosthesis (cemented, porous coated or similar) (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	

OPERATIONS		ORTHOPAEDIC
49315	HIP, arthroplasty of, unipolar or bipolar (Anaes.) (Assist.) Fee: \$687.00 Benefit: 75% = \$515.25 85% = \$629.90	
49318	HIP, total replacement arthroplasty of, including minor bone grafting (Anaes.) (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	
49319	HIP, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) Fee: \$1,877.15 Benefit: 75% = \$1,407.90 85% = \$1,820.05	
49321	HIP, total replacement arthroplasty of, including major bone grafting, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,297.75 Benefit: 75% = \$973.35 85% = \$1,240.65	
49324	HIP, total replacement arthroplasty of, revision procedure including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,526.70 Benefit: 75% = \$1,145.05 85% = \$1,469.60	
49327	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to acetabulum, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,755.60 Benefit: 75% = \$1,316.70 85% = \$1,698.50	
49330	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to femur, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,755.60 Benefit: 75% = \$1,316.70 85% = \$1,698.50	
49333	HIP, total replacement arthroplasty of, revision procedure requiring bone grafting to both acetabulum and femur, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,984.65 Benefit: 75% = \$1,488.50 85% = \$1,927.55	
49336	HIP, treatment of a fracture of the femur where revision total hip replacement is required as part of the treatment of the fracture (not including intra-operative fracture), being a service associated with a service to which items 49324 to 49333 apply (Anaes.) (Assist.) Fee: \$290.00 Benefit: 75% = \$217.50 85% = \$246.50	
49339	HIP, revision total replacement of, requiring anatomic specific allograft of proximal femur greater than 5 cm in length (Anaes.) (Assist.) Fee: \$2,251.70 Benefit: 75% = \$1,688.80 85% = \$2,194.60	
49342	HIP, revision total replacement of, requiring anatomic specific allograft of acetabulum (Anaes.) (Assist.) Fee: \$2,251.70 Benefit: 75% = \$1,688.80 85% = \$2,194.60	
49345	HIP, revision total replacement of, requiring anatomic specific allograft of both femur and acetabulum (Anaes.) (Assist.) Fee: \$2,671.60 Benefit: 75% = \$2,003.70 85% = \$2,614.50	
49346	HIP, revision arthroplasty with replacement of acetabular liner or ceramic head, not requiring removal of femoral component or acetabular shell (Anaes.) (Assist.) Fee: \$687.00 Benefit: 75% = \$515.25 85% = \$629.90	
49360	HIP, diagnostic arthroscopy of (Anaes.) (Assist.) Fee: \$278.90 Benefit: 75% = \$209.20 85% = \$237.10	
49363	HIP, diagnostic arthroscopy of, with synovial biopsy (Anaes.) (Assist.) Fee: \$335.80 Benefit: 75% = \$251.85 85% = \$285.45	
49366	HIP, arthroscopic surgery of (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	
KNEE		
49500	KNEE, arthrotomy of, involving 1 or more of; capsular release, biopsy or lavage, or removal of loose body or foreign body (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
49503	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello- femoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Group applies) - any 1 procedure (Anaes.) (Assist.) Fee: \$396.95 Benefit: 75% = \$297.75 85% = \$339.85	

OPERATIONS		ORTHOPAEDIC
49506	KNEE, meniscectomy of, repair of collateral or cruciate ligament, patellectomy of, chondroplasty of, osteoplasty of, patello-femoral stabilisation or single transfer of ligament or tendon or any other single procedure (not being a service to which another item in this Group applies) - any 2 or more procedures (Anaes.) (Assist.) Fee: \$595.40 Benefit: 75% = \$446.55 85% = \$538.30	
49509	KNEE, total synovectomy or arthrodesis of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
49512	KNEE, arthrodesis of, with removal of prosthesis (Anaes.) (Assist.) Fee: \$877.80 Benefit: 75% = \$658.35 85% = \$820.70	
49515	KNEE, removal of prosthesis, cemented or uncemented, including associated cement, as the first stage of a 2 stage procedure (Anaes.) (Assist.) Fee: \$687.00 Benefit: 75% = \$515.25 85% = \$629.90	
49517	KNEE, hemiarthroplasty of (Anaes.) (Assist.) Fee: \$978.10 Benefit: 75% = \$733.60 85% = \$921.00	
49518	KNEE, total replacement arthroplasty of (Anaes.) (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	
49519	KNEE, total replacement arthroplasty of, including associated minor grafting, if performed - bilateral (Anaes.) (Assist.) Fee: \$1,877.15 Benefit: 75% = \$1,407.90 85% = \$1,820.05	
49521	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur or tibia, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,297.75 Benefit: 75% = \$973.35 85% = \$1,240.65	
49524	KNEE, total replacement arthroplasty of, requiring major bone grafting to femur and tibia, including obtaining of graft (Anaes.) (Assist.) Fee: \$1,526.70 Benefit: 75% = \$1,145.05 85% = \$1,469.60	
49527	KNEE, total replacement arthroplasty of, revision procedure, including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,297.75 Benefit: 75% = \$973.35 85% = \$1,240.65	
49530	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to femur or tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,603.05 Benefit: 75% = \$1,202.30 85% = \$1,545.95	
49533	KNEE, total replacement arthroplasty of, revision procedure, requiring bone grafting to both femur and tibia, including obtaining of graft and including removal of prosthesis (Anaes.) (Assist.) Fee: \$1,832.00 Benefit: 75% = \$1,374.00 85% = \$1,774.90	
49534	KNEE, patello-femoral joint of, total replacement arthroplasty as a primary procedure (Anaes.) (Assist.) Fee: \$364.40 Benefit: 75% = \$273.30 85% = \$309.75	
49536	KNEE, repair or reconstruction of, for chronic instability (open or arthroscopic, or both) involving either cruciate or collateral ligaments, including notchplasty when performed (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
49539	KNEE, reconstructive surgery of cruciate ligaments (open or arthroscopic, or both), including notchplasty when performed and surgery to other internal derangements, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
49542	KNEE, reconstructive surgery to cruciate ligaments (open or arthroscopic, or both), including notchplasty, meniscus repair, extracapsular procedure and debridement when performed (Anaes.) (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	
49545	KNEE, revision arthrodesis of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
49548	KNEE, revision of patello-femoral stabilisation (Anaes.) (Assist.) Fee: \$763.30 Benefit: 75% = \$572.50 85% = \$706.20	
49551	KNEE, revision of procedures to which item 49536 , 49539 or 49542 applies (Anaes.) (Assist.) Fee: \$1,068.55 Benefit: 75% = \$801.45 85% = \$1,011.45	

OPERATIONS		ORTHOPAEDIC	
49554	KNEE, revision of total replacement of, by anatomic specific allograft of tibia or femur (Anaes.) (Assist.) Fee: \$1,526.70 Benefit: 75% = \$1,145.05 85% = \$1,469.60		
49557	KNEE, diagnostic arthroscopy of (including biopsy, simple trimming of meniscal margin or plica) - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15		
49558	KNEE, arthroscopic surgery of, involving 1 or more of: debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15		
49559	KNEE, arthroscopic surgery of, involving chondroplasty requiring multiple drilling or carbon fibre (or similar) implant; including any associated debridement or oestoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$331.30 Benefit: 75% = \$248.50 85% = \$281.65		
49560	KNEE, arthroscopic surgery of, involving 1 or more of: meniscectomy, removal of loose body or lateral release - not being a service associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$447.20 Benefit: 75% = \$335.40 85% = \$390.10		
49561	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: meniscectomy, removal of loose body or lateral release; where the procedure includes associated debridement, osteoplasty or chondroplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$546.55 Benefit: 75% = \$409.95 85% = \$489.45		
49562	KNEE, ARTHROSCOPIC SURGERY OF, involving 1 or more of: meniscectomy, removal of loose body or lateral release; where the procedure includes chondroplasty requiring multiple drilling or carbon fibre (or similar) implant and associated debridement or osteoplasty - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$596.30 Benefit: 75% = \$447.25 85% = \$539.20		
49563	KNEE, arthroscopic surgery of, involving 1 or more of: meniscus repair; osteochondral graft; or chondral graft - not associated with any other arthroscopic procedure of the knee region (Anaes.) (Assist.) Fee: \$645.90 Benefit: 75% = \$484.45 85% = \$588.80		
49564	KNEE, patello-femoral stabilisation of, combined arthroscopic and open procedure, including lateral release, medial capsulorrhaphy and tendon transfer (Anaes.) (Assist.) Fee: \$745.05 Benefit: 75% = \$558.80 85% = \$687.95		
49566	KNEE, arthroscopic total synovectomy of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60		
49569	KNEE, mobilisation for post-traumatic stiffness, by multiple muscle or tendon release (quadricepsplasty) (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60		
	ANKLE		
49700	ANKLE, diagnostic arthroscopy of, including biopsy (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15		
49703	ANKLE, arthroscopic surgery of (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05		
49706	ANKLE, arthrotomy of, involving 1 or more of: lavage, removal of loose body or division of contracture (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15		
49709	ANKLE, ligamentous stabilisation of (Anaes.) (Assist.) Fee: \$572.45 Benefit: 75% = \$429.35 85% = \$515.35		
49712	ANKLE, arthrodesis of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60		
49715	ANKLE, total joint replacement of (Anaes.) (Assist.) Fee: \$915.95 Benefit: 75% = \$687.00 85% = \$858.85		
49718	ANKLE, Achilles' tendon or other major tendon, repair of (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55		

OPERATIONS		ORTHOPAEDIC
49721	ANKLE, Achilles' tendon rupture managed by non-operative treatment Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30	
49724	ANKLE, Achilles' tendon, secondary repair or reconstruction of (Anaes.) (Assist.) Fee: \$534.40 Benefit: 75% = \$400.80 85% = \$477.30	
49727	ANKLE, Achilles' tendon, operation for lengthening (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
	FOOT	
49800	FOOT, flexor or extensor tendon, primary repair of (Anaes.) Fee: \$106.90 Benefit: 75% = \$80.20 85% = \$90.90	
49803	FOOT, flexor or extensor tendon, secondary repair of (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80	
49806	FOOT, subcutaneous tenotomy of, 1 or more tendons (Anaes.) Fee: \$106.90 Benefit: 75% = \$80.20 85% = \$90.90	
49809	FOOT, open tenotomy of, with or without tenoplasty (Anaes.) Fee: \$175.50 Benefit: 75% = \$131.65 85% = \$149.20	
49812	FOOT, tendon or ligament transplantation of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
49815	FOOT, triple arthrodesis of (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
49818	FOOT, excision of calcaneal spur (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	
49821	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - unilateral (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
49824	FOOT, correction of hallux valgus or hallux rigidus by excision arthroplasty (Keller's or similar procedure) - bilateral (Anaes.) (Assist.) Fee: \$614.50 Benefit: 75% = \$460.90 85% = \$557.40	
49827	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - unilateral (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
49830	FOOT, correction of hallux valgus by transfer of adductor hallucis tendon - bilateral (Anaes.) (Assist.) Fee: \$667.90 Benefit: 75% = \$500.95 85% = \$610.80	
49833	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - unilateral (Anaes.) (Assist.) Fee: \$419.85 Benefit: 75% = \$314.90 85% = \$362.75	
49836	FOOT, correction of hallux valgus by osteotomy of first metatarsal including internal fixation where performed - bilateral (Anaes.) (Assist.) Fee: \$725.10 Benefit: 75% = \$543.85 85% = \$668.00	
49837	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallucis tendon, including internal fixation where performed - unilateral (Anaes.) (Assist.) Fee: \$524.80 Benefit: 75% = \$393.60 85% = \$467.70	
49838	FOOT, correction of hallux valgus by osteotomy of first metatarsal and transfer of adductor hallucis tendon, including internal fixation where performed - bilateral (Anaes.) (Assist.) Fee: \$906.30 Benefit: 75% = \$679.75 85% = \$849.20	
49839	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - unilateral (Anaes.) (Assist.) Fee: \$419.85 Benefit: 75% = \$314.90 85% = \$362.75	
49842	FOOT, correction of hallux rigidus or hallux valgus by prosthetic arthroplasty - bilateral (Anaes.) (Assist.) Fee: \$725.10 Benefit: 75% = \$543.85 85% = \$668.00	

OPERATIONS		ORTHOPAEDIC
49845	FOOT, arthrodesis of, first metatarso-phalangeal joint (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
49848	FOOT, correction of claw or hammer toe (Anaes.) Fee: \$129.80 Benefit: 75% = \$97.35 85% = \$110.35	
49851	FOOT, correction of claw or hammer toe with internal fixation (Anaes.) Fee: \$167.90 Benefit: 75% = \$125.95 85% = \$142.75	
49854	FOOT, radical plantar fasciotomy or fasciectomy of (Anaes.) (Assist.) Fee: \$305.35 Benefit: 75% = \$229.05 85% = \$259.55	
49857	FOOT, metatarso-phalangeal joint replacement (Anaes.) (Assist.) Fee: \$282.40 Benefit: 75% = \$211.80 85% = \$240.05	
49860	FOOT, synovectomy of metatarso-phalangeal joint, single joint (Anaes.) (Assist.) Fee: \$228.90 Benefit: 75% = \$171.70 85% = \$194.60	
49863	FOOT, synovectomy of metatarso-phalangeal joint, 2 or more joints (Anaes.) (Assist.) Fee: \$343.55 Benefit: 75% = \$257.70 85% = \$292.05	
49866	FOOT, neurectomy for plantar or digital neuritis (Morton's or Bett's syndrome) (Anaes.) (Assist.) Fee: \$244.15 Benefit: 75% = \$183.15 85% = \$207.55	
49878	TALIPES EQUINOVARUS, calcaneo valgus or metatarus varus, treatment by cast, splint or manipulation - each attendance (Anaes.) Fee: \$45.80 Benefit: 75% = \$34.35 85% = \$38.95	
OTHER JOINTS		
50100	JOINT, diagnostic arthroscopy of (including biopsy), not being a service to which another item in this Group applies and not being a service associated with any other arthroscopic procedure (Anaes.) (Assist.) Fee: \$221.30 Benefit: 75% = \$166.00 85% = \$188.15	
50102	JOINT, arthroscopic surgery of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	
50103	JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15	
50104	JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$253.20 Benefit: 75% = \$189.90 85% = \$215.25	
50106	JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
50109	JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50	
50112	CICATRICIAL FLEXION OR EXTENSION CONTRACTION OF JOINT, correction of, involving tissues deeper than skin and subcutaneous tissue, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$292.75 Benefit: 75% = \$219.60 85% = \$248.85	
50115	JOINT or JOINTS, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40	
50118	SUBTALAR JOINT, arthrodesis of (Anaes.) (Assist.) Fee: \$351.05 Benefit: 75% = \$263.30 85% = \$298.40	
50121	GREATER TROCHANTER, transplantation of ileopsoas tendon to (Anaes.) (Assist.) Fee: \$687.00 Benefit: 75% = \$515.25 85% = \$629.90	

OPERATIONS		ORTHOPAEDIC
50124	JOINT or other SYNOVIAL CAVITY, aspiration of, injection into, or both of these procedures; payable on not more than 25 occasions in any 12 month period (Anaes.) (See para T8.85 of explanatory notes to this Category) Fee: \$24.00 Benefit: 75% = \$18.00 85% = \$20.40	
50125	JOINT OR OTHER SYNOVIAL CAVITY, aspiration of, or injection into, or both of these procedures - <i>where it can be demonstrated that a 26th or subsequent treatment (including any treatments to which item 50124 applies) is indicated in a 12 month period</i> (Anaes.) (See para T8.85 of explanatory notes to this Category) Fee: \$24.00 Benefit: 75% = \$18.00 85% = \$20.40	
50127	JOINT OR JOINTS, arthroplasty of, by any technique not being a service to which another item applies (Anaes.) (Assist.) Fee: \$569.60 Benefit: 75% = \$427.20 85% = \$512.50	
50130	JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$253.20 Benefit: 75% = \$189.90 85% = \$215.25	
MALIGNANT DISEASE		
50200	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR, biopsy of (not including aftercare) (Anaes.) Fee: \$152.65 Benefit: 75% = \$114.50 85% = \$129.80	
50203	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR, lesional or marginal excision of (Anaes.) (Assist.) Fee: \$335.85 Benefit: 75% = \$251.90 85% = \$285.50	
50206	BONE TUMOUR, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05	
50209	BONE TUMOUR, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60	
50212	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, without reconstruction (Anaes.) (Assist.) Fee: \$1,335.80 Benefit: 75% = \$1,001.85 85% = \$1,278.70	
50215	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR affecting the long bones of leg or arm, enbloc resection of, with compartmental or wide excision of soft tissue, with intercalary reconstruction (prosthesis, allograft or autograft) (Anaes.) (Assist.) Fee: \$1,679.30 Benefit: 75% = \$1,259.50 85% = \$1,622.20	
50218	MALIGNANT TUMOUR of LONG BONE, enbloc resection of, with replacement or arthrodesis of adjacent joint (Anaes.) (Assist.) Fee: \$2,213.65 Benefit: 75% = \$1,660.25 85% = \$2,156.55	
50221	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of (Anaes.) (Assist.) Fee: \$2,060.90 Benefit: 75% = \$1,545.70 85% = \$2,003.80	
50224	MALIGNANT or AGGRESSIVE SOFT TISSUE TUMOUR of PELVIS, SACRUM or SPINE; or SCAPULA and SHOULDER, enbloc resection of, with reconstruction by prosthesis, allograft or autograft (Anaes.) (Assist.) Fee: \$2,289.90 Benefit: 75% = \$1,717.45 85% = \$2,232.80	
50227	MALIGNANT BONE TUMOUR, enbloc resection of, with massive anatomic specific allograft or autograft, with or without prosthetic replacement (Anaes.) (Assist.) Fee: \$2,671.60 Benefit: 75% = \$2,003.70 85% = \$2,614.50	
50230	BENIGN TUMOUR, resection of, requiring anatomic specific allograft, with or without internal fixation (Anaes.) (Assist.) Fee: \$1,373.95 Benefit: 75% = \$1,030.50 85% = \$1,316.85	
50233	MALIGNANT TUMOUR, amputation for, hemipelvectomy or interscapulo-thoracic (Anaes.) (Assist.) Fee: \$1,755.60 Benefit: 75% = \$1,316.70 85% = \$1,698.50	
50236	MALIGNANT TUMOUR, amputation for, hip disarticulation, shoulder disarticulation or proximal third femur (Anaes.) (Assist.) Fee: \$1,373.95 Benefit: 75% = \$1,030.50 85% = \$1,316.85	

OPERATIONS		ORTHOPAEDIC
50239	MALIGNANT TUMOUR, amputation for, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$915.95 Benefit: 75% = \$687.00 85% = \$858.85	
CONGENITAL ORTHOPAEDIC SURGERY		
LIMB LENGTHENING AND DEFORMITY CORRECTION		
50300	JOINT DEFORMITY, slow correction of, using ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.) Fee: \$938.60 Benefit: 75% = \$703.95 85% = \$881.50	
50303	LIMB LENGTHENING, up to and including 5cm, requiring slow distraction under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, with or without application of a ring fixator or similar device, including all associated attendances - payable only once in any 12 month period (Anaes.) (Assist.) Fee: \$1,281.45 Benefit: 75% = \$961.10 85% = \$1,224.35	
50306	LIMB LENGTHENING, where the lengthening is bipolar, or bone transport is performed or where the fixator is extended to correct an adjacent joint deformity (Anaes.) (Assist.) Fee: \$2,000.90 Benefit: 75% = \$1,500.70 85% = \$1,943.80	
50309	RING FIXATOR OR SIMILAR DEVICE, adjustment of, with or without insertion or removal of fixation pins, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50303 or 50306 applies (Anaes.) (Assist.) Fee: \$247.25 Benefit: 75% = \$185.45 85% = \$210.20	
50312	ANKLE, synovectomy of (Anaes.) (Assist.) Fee: \$567.65 Benefit: 75% = \$425.75 85% = \$510.55	
50315	TALIPES EQUINOVARUS, posterior release of (Anaes.) (Assist.) Fee: \$562.05 Benefit: 75% = \$421.55 85% = \$504.95	
50318	TALIPES EQUINOVARUS, medial release of (Anaes.) (Assist.) Fee: \$562.05 Benefit: 75% = \$421.55 85% = \$504.95	
50321	TALIPES EQUINOVARUS, combined postero-medial release of (Anaes.) (Assist.) Fee: \$753.10 Benefit: 75% = \$564.85 85% = \$696.00	
50324	TALIPES EQUINOVARUS, combined postero-medial release of, revision procedure (Anaes.) (Assist.) Fee: \$1,073.55 Benefit: 75% = \$805.20 85% = \$1,016.45	
50327	TALIPES EQUINOVARUS, bilateral procedures (Anaes.) (Assist.) Fee: \$1,309.50 Benefit: 75% = \$982.15 85% = \$1,252.40	
50330	TALIPES EQUINOVARUS, or talus, vertical congenital - post operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility, not being a service to which item 50315 , 50318 , 50321 , 50324 or 50327 applies (Anaes.) Fee: \$185.40 Benefit: 75% = \$139.05 85% = \$157.60	
50333	TARSAL COALITION, excision of, with interposition of muscle, fat graft or similar graft (Anaes.) (Assist.) Fee: \$500.20 Benefit: 75% = \$375.15 85% = \$443.10	
50336	TALUS, VERTICAL, CONGENITAL, combined anterior and posterior reconstruction (Anaes.) (Assist.) Fee: \$747.55 Benefit: 75% = \$560.70 85% = \$690.45	
50339	FOOT AND ANKLE, tibialis anterior tendon (split or whole) transfer to lateral column (Anaes.) (Assist.) Fee: \$455.30 Benefit: 75% = \$341.50 85% = \$398.20	
50342	FOOT AND ANKLE, tibialis or tibialis posterior tendon transfer, through the interosseous membrane to anterior or posterior aspect of foot (Anaes.) (Assist.) Fee: \$528.30 Benefit: 75% = \$396.25 85% = \$471.20	
50345	HYPEREXTENSION DEFORMITY OF TOE, release incorporating V-Y plasty of skin, lengthening of extensor tendons and release of capsule contracture (Anaes.) (Assist.) Fee: \$281.05 Benefit: 75% = \$210.80 85% = \$238.90	

OPERATIONS		ORTHOPAEDIC	
	HIP, KNEE AND LEG PROCEDURES		
50348	KNEE, deformity of, post-operative manipulation and change of plaster, performed under general anaesthesia in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$185.40	Benefit: 75% = \$139.05	85% = \$157.60
50349	HIP, congenital dislocation of, treatment of, by closed reduction (Anaes.) Fee: \$129.80	Benefit: 75% = \$97.35	85% = \$110.35
50350	HIP, congenital dislocation of, open reduction of (Anaes.) (Assist.) Fee: \$687.00	Benefit: 75% = \$515.25	85% = \$629.90
50351	HIP, developmental dislocation of, open reduction of (Anaes.) (Assist.) Fee: \$809.35	Benefit: 75% = \$607.05	85% = \$752.25
50352	HIP, congenital dislocation of, treatment of, involving supervision of splint, harness or cast - each attendance (Anaes.) Fee: \$45.80	Benefit: 75% = \$34.35	85% = \$38.95
50353	HIP SPICA, initial application of, for congenital dislocation of hip (excluding aftercare) (Anaes.) (Assist.) Fee: \$287.65	Benefit: 75% = \$215.75	85% = \$244.55
50354	TIBIA, pseudarthrosis of, congenital, resection and internal fixation (Anaes.) (Assist.) Fee: \$1,062.25	Benefit: 75% = \$796.70	85% = \$1,005.15
50357	KNEE, LEG OR THIGH, rectus femoris tendon transfer, or medial or lateral hamstring tendon transfer (Anaes.) (Assist.) Fee: \$455.30	Benefit: 75% = \$341.50	85% = \$398.20
50360	KNEE, LEG OR THIGH, combined medial and lateral hamstring tendon transfer (Anaes.) (Assist.) Fee: \$528.30	Benefit: 75% = \$396.25	85% = \$471.20
50363	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, unilateral (Anaes.) (Assist.) Fee: \$404.70	Benefit: 75% = \$303.55	85% = \$347.60
50366	KNEE, contracture of, posterior release involving multiple tendon lengthening or tenotomies, bilateral (Anaes.) (Assist.) Fee: \$708.20	Benefit: 75% = \$531.15	85% = \$651.10
50369	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, unilateral (Anaes.) (Assist.) Fee: \$528.30	Benefit: 75% = \$396.25	85% = \$471.20
50372	KNEE, contracture of, posterior release involving multiple tendon lengthening with or without tenotomies and release of joint capsule with or without cruciate ligaments, bilateral (Anaes.) (Assist.) Fee: \$927.35	Benefit: 75% = \$695.55	85% = \$870.25
50375	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, unilateral (Anaes.) (Assist.) Fee: \$404.70	Benefit: 75% = \$303.55	85% = \$347.60
50378	HIP, contracture of, medial release, involving lengthening of, or division of the adductors and psoas with or without division of the obturator nerve, bilateral (Anaes.) (Assist.) Fee: \$708.20	Benefit: 75% = \$531.15	85% = \$651.10
50381	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, unilateral (Anaes.) (Assist.) Fee: \$528.30	Benefit: 75% = \$396.25	85% = \$471.20
50384	HIP, contracture of, anterior release, involving lengthening of, or division of the hip flexors and psoas with or without division of the joint capsule, bilateral (Anaes.) (Assist.) Fee: \$927.35	Benefit: 75% = \$695.55	85% = \$870.25
50387	HIP, iliopsoas tendon transfer to greater trochanter, or transfer of abdominal musculature to greater trochanter, or transfer of adductors to ischium (Anaes.) (Assist.) Fee: \$528.30	Benefit: 75% = \$396.25	85% = \$471.20
50390	PERTHES, CEREBRAL PALSY, or other neuromuscular conditions, affecting hips or knees, application of cast under general anaesthesia, performed in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$185.40	Benefit: 75% = \$139.05	85% = \$157.60

OPERATIONS		ORTHOPAEDIC
50393	PELVIS, bone graft or shelf procedures for acetabular dysplasia (Anaes.) (Assist.) Fee: \$685.65 Benefit: 75% = \$514.25 85% = \$628.55	
50394	ACETABULAR DYSPLASIA, treatment of, by multiple peri-acetabular osteotomy, including internal fixation where performed (Anaes.) (Assist.) Fee: \$2,251.70 Benefit: 75% = \$1,688.80 85% = \$2,194.60	
SHOULDER, ARM AND FOREARM PROCEDURES		
50396	HAND, congenital abnormalities or duplication of digits, amputation or splitting of phalanx or phalanges, with ligament or joint reconstruction (Anaes.) (Assist.) Fee: \$376.65 Benefit: 75% = \$282.50 85% = \$320.20	
50399	FOREARM, RADIAL APLASIA OR DYSPLASIA (radial club hand), centralisation or radialisation of (Anaes.) (Assist.) Fee: \$747.55 Benefit: 75% = \$560.70 85% = \$690.45	
50402	TORTICOLLIS, bipolar release of sternocleidomastoid muscle and associated soft tissue (Anaes.) (Assist.) Fee: \$342.85 Benefit: 75% = \$257.15 85% = \$291.45	
50405	ELBOW, flexorplasty, or tendon transfer to restore elbow function (Anaes.) (Assist.) Fee: \$466.50 Benefit: 75% = \$349.90 85% = \$409.40	
50408	SHOULDER, congenital or developmental dislocation, open reduction of (Anaes.) (Assist.) Fee: \$809.35 Benefit: 75% = \$607.05 85% = \$752.25	
AMPUTATIONS OR RECONSTRUCTIONS FOR CONGENITAL DEFORMITIES		
50411	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion (Anaes.) (Assist.) Fee: \$1,062.25 Benefit: 75% = \$796.70 85% = \$1,005.15	
50414	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the femur by resection of the distal femur and proximal tibia followed by knee fusion and rotationplasty (Anaes.) (Assist.) Fee: \$1,433.15 Benefit: 75% = \$1,074.90 85% = \$1,376.05	
50417	LOWER LIMB DEFICIENCY, treatment of congenital deficiency of the tibia by reconstruction of the knee, involving transfer of fibula or tibia, and repair of quadriceps mechanism (Anaes.) (Assist.) Fee: \$1,062.25 Benefit: 75% = \$796.70 85% = \$1,005.15	
50420	PATELLA, congenital dislocation of, reconstruction of the quadriceps (Anaes.) (Assist.) Fee: \$876.80 Benefit: 75% = \$657.60 85% = \$819.70	
50423	TIBIA, FIBULA OR BOTH, congenital deficiency of, transfer of the fibula to tibia, with internal fixation (Anaes.) (Assist.) Fee: \$809.35 Benefit: 75% = \$607.05 85% = \$752.25	
TUMOROUS CONDITIONS		
50426	DIAPHYSEAL ACLASIA, removal of lesion or lesions from bone - 1 approach (Anaes.) (Assist.) Fee: \$376.65 Benefit: 75% = \$282.50 85% = \$320.20	

ASSISTANCE AT OPERATIONS		ASSISTANCE AT OPERATIONS	
GROUP T9 - ASSISTANCE AT OPERATIONS			
	<p>NOTE: Benefit in respect of assistance at an operation is not payable unless the assistance is rendered by a medical practitioner other than the anaesthetist or assistant anaesthetist. The amount specified is the amount payable whether the assistance is rendered by one or more than one medical practitioner.</p> <p>Assistance at any operation identified by the word "Assist." for which the fee does not exceed \$452.70 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$452.70 (See para T9.2 of explanatory notes to this Category)</p>		
51300	Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
51303	<p>Assistance at any operation identified by the word "Assist." for which the fee exceeds \$452.70 or at a series of operations identified by the word "Assist." for which the aggregate fee exceeds \$452.70 (See para T9.3 of explanatory notes to this Category)</p> <p>Derived Fee: one fifth of the established fee for the operation or combination of operations</p>		
51306	Assistance at a delivery involving Caesarean section Fee: \$101.10	Benefit: 75% = \$75.85	85% = \$85.95
51309	<p>Assistance at a series or combination of operations which have been identified by the word "Assist." and assistance at a delivery involving Caesarean section (See para T9.4 of explanatory notes to this Category)</p> <p>Derived Fee: one fifth of the established fee for the operation or combination of operations (the fee for item 16520 being the Schedule fee for the Caesarean section component in the calculation of the established fee)</p>		
51312	<p>Assistance at any interventional obstetric procedure covered by items 16606, 16609, 16612, 16615, 16627 and 16633 Derived Fee: one fifth of the established fee for the procedure or combination of procedures</p>		
51315	Assistance at cataract and intraocular lens surgery covered by item 42698, 42701, 42702, 42704 or 42707 , when performed in association with services covered by item 42551 to 42569 , 42653 , 42656 , 42746 , 42749 , 42752 , 42776 or 42779 Fee: \$220.85	Benefit: 75% = \$165.65	85% = \$187.75
51318	<p>Assistance at cataract and intraocular lens surgery where patient has: - total loss of vision, including no potential for central vision, in the fellow eye; or - previous significant surgical complication in the fellow eye; or - pseudo exfoliation, subluxed lens, iridodonesis, phacodonesis, retinal detachment, corneal scarring, pre-existing uveitis, bound down miosed pupil, nanophthalmos, spherophakia, Marfan's syndrome, homocysteinuria or previous blunt trauma causing intraocular damage</p> <p>Fee: \$145.75</p>		
	Benefit: 75% = \$109.35	85% = \$123.90	

INDEX TO GENERAL MEDICAL SERVICES

PLEASE NOTE:

This index is a reference point for medical services which attract Medicare benefits under items included in the Schedule of General Medical Services. Medical practitioners should peruse the actual description of the item in the Schedule to ensure the correct item number is selected and to ascertain whether there are any restrictions relating to the payment of benefits. Restrictions are, as far as practicable, included in the description of the item. Otherwise they will be outlined in the notes immediately preceding the particular Category of the Schedule.



Service	Item	Service	Item
A			
Abbe flap, reconstruction of cleft lip	45701	Alimentary continuity, primary restoration	41843
reconstruction of lip or eyelid	45671	obstruction, neonatal, laparotomy for	43825
Abdomen, burst, repair of	30403	Allergens, epicutaneous patch testing	12012-12021
Abdominal apron, wedge excision	30165,30168,30171	skin sensitivity testing	12000,12003
musculature transfer to greater trochanter	50387	Alopecia, hair transplantation for	45560
paracentesis	30406	Amnio-infusion	16621
viscera, operations involving laparotomy	30387	Amniocentesis, diagnostic	16600
wall vitello intestinal remnant, excision of	43942	therapeutic	16618
Abdomino-perineal resection, rectum and anus	32039-32046	Amputation, limb, digit etc.	44325-44376
Abdomino-vaginal op for stress incontinence	35602,35605	stump, reamputation of	44376
Abdominoplasty, Pitanguy type	30177	stump, revision of	46483
Abortion, threatened, treatment of	16505	stump, trimming of	*
Abrasive therapy	45021,45024	Anaesthetic, Relative Value Guide	20100-25205
Abscess, anal, drainage of	32174,32175	abdomen, lower	20800-20884
Bartholin's, incision of	35520	abdomen, upper	20700-20799
appendiceal, laparotomy for drainage	30394	anaesthesia in connection with burns	21878-21887
breast, exploration and drainage	31551	anaesthesia in connection with dental services	22900-22905
deep, percutaneous drainage	30224	anaesthesia in connection with radiological diagnostic or	
drainage tube, exchange of	30225	therapeutic procedures	21900-21980
extradural, laminectomy for	40309	anaesthesia modifiers	25000-25030
intra-orbital, drainage of	42572	anaesthesia time	23010-24136
intracranial, excision of	39903	arm, upper (and elbow)	21700-21790
ischio-rectal, drainage of	32174,32175	assistance at anaesthesia	25200-25205
laparotomy for drainage of	30394	assistance time	23010-24136
large, incision and drainage, with GA	30223	assistance, modifiers	25000-25030
liver, open abdominal drainage of	30431	forearm, wrist & hand	21800-21872
middle ear, operation for	41626	head	20100-20225
pancreatic, laparotomy, external drainage	30575	intrathoracic	20500-20560
pelvic, laparotomy for drainage of	30394	knee & popliteal area	21300-21440
peritonsillar, incision of	41807	leg, lower (below knee)	21460-21532
prostate, drainage of	37212,37221	leg, upper (except knee)	21195-21280
retroperitoneal, drainage of	30402	neck	20300-20352
small, incision without drainage	*	pelvis (except hip)	21100-21170
small, incision, drainage, without GA	30219	perfusion, modifiers	25000-25020,25050
subperiosteal	43500-43524	perfusion, time	23010-24136
subphrenic, laparotomy for drainage	30394	perfusion, whole body, cardiac bypass	22060
Accessory bone, osteotomy or osteectomy of	48400	perineum	20900-20954
Acetabular dysplasia, pelvis, bone graft/shelf procedure	50393	shoulder & axilla	21600-21682
Acetabulum, treatment of fracture of	47492-47510	spine & spinal cord	20600-20690
Achilles' tendon, operation for lengthening	49727	thorax	20400-20474
tendon, repair of	49718,49721,49724	Anal canal, laser therapy (restriction)	35539,35542,35545
Acoustic neuroma, removal of	41575-41579	fissure, operation for, including excision	32150
Acupuncture, by a medical practitioner	173-195	fistula, excision/repair	32156-32165
Adductors to ischium transfer	50387	fistula, readjustment of Seton	32166
Adenoids and tonsils, removal of	41788-41793	graciloplasty	32203
removal of	41800,41801	graciloplasty, insertion of stimulator & electrode	32209
Adhesions, division of, via laparoscope	35637,31450,31452	incontinence, Parks' procedure	32126
division of, with laparoscopy	30393	manometry, pelvic floor abnormalities	11830
division of, with laparotomy	30376,30378,30379	skin tags or polyps, excision of	32142,32145
labial, separation of	*	sphincter, direct repair of	32129
liver, destruction of by cryotherapy	30419	sphincterotomy, independent, Hirschsprung's	43999
nasal, division of	41683	stricture, anoplasty for	32123
pharyngeal, division of	41758	warts, removal under GA or nerve block	32177,32180
preputial, breakdown of	*	Anastomosis, aorta, congenital heart disease	38706,38709
Administration of	16018	arterial/venous, independent	32766
Adrenal gland, excision of	36500	arterial/venous, with other operation	32769
gland tumour, excision of	30324	arteriovenous, upper or lower limb	34503,34509
hyperplasia, congenital, vaginoplasty for	37851	facio-hypoglossal/accessory nerve	39503
Alcohol, injection of trigeminal nerve/s	39100	ileo-rectal, with total colectomy	32012
local infiltration, nerve or muscle	*	intrathoracic, congenital heart disease	38727,38730
retrobulbar injection of	42824	microvascular, in plastic surgery	45502
		oesophageal atresia, neonatal	43855
		saphenous vein, for femoral vein bypass	34809
		vena cava, for congenital heart disease	38721,38724

* Payable on attendance basis

Service	Item	Service	Item
Aneurysm, cerebrovascular, clipping/reinforcement	39800	endarterectomy	33509
intracranial proximal artery clipping	39806	interruption, repair of	38712
intracranial, ligation cervical vessels	39812	valve leaflet/s, decalcification of	38483
left ventricular, plication of	38506	Aorto-duodenal fistula, repair of	34160,34163,34166
left ventricular, resection	38507,38508	Aorto-femoral endarterectomy	33515
major artery, replacement/repair	33050-33181	Aorto-iliac endarterectomy	33512
Angiofibroma, face/neck, removal by laser excision	30190	Aortopexy for tracheomalacia	43909
nasopharyngeal, removal	41767	Appendiceal abscess, laparotomy for drainage	30394
Angioma, cauterisation/injection into	45027	Appendicectomy	30571,30572,30574
excision of	45030-45036	Appendicostomy	30375
Angioplasty, peripheral laser	35315	Appendix, ruptured, laparotomy for drainage	30394
transluminal balloon	35300-35305	Arachnoidal cyst, craniotomy for	39718
Angioscopy	35324,35327	Areola, reconstruction of	45545,45546
Ankle, achilles tendon, operation for lengthening	49727	Arm, amputation or disarticulation of	44328
achilles tendon, repair of	49718,49721,49724	Arnold Chiari malformation, decompression of	40106
and foot, tibialis tendon transfer	50339,50342	Arrhythmia ablation	38287,38290,38293
arthrodesis of	49712	surgery	38512-38524
arthroscopic surgery of	49703	Arterial anastomosis, not otherwise covered	32766,32769
arthroscopy of, diagnostic	49700	atherectomy, peripheral	35312
arthrotomy of	49706	cannulation for infusion chemotherapy, open	34524
dislocation, treatment of	47063,47066	catheterisation, peripheral	35317-35321
fracture, treatment of	47594-47603	line for blood pressure monitoring	13876
jerk test for half relaxation time	*	puncture and blood collection, diagnostic	13839
ligamentous stabilisation of	49709	Arteries, major, access as part of re-operation	35202
major tendon repair	49718	Arteriography, operative	35200
synovectomy of	50312	Arteriovenous access device, insertion of	34512
tibialis tendon transfer	50339,50342	access device, prosthetic, correction of	34518
total joint replacement	49715	access device, thrombectomy of	34515
Annuloplasty, heart valve	38475,38477,38478	anastomosis of upper or lower limb	34503,34509
Anophthalmic orbit, insertion cartilage/implant	42518	fistula extremity, surgically created, closure	34130
orbit, placement of motility integrating peg	42518	fistula, dissection and ligation/repair	34112-34127
orbit, removal of implant from socket	42518	fistula, ligation of cervical vessel/s	39812
socket, treatment as secondary procedure	42521	fistula, stenosis of, correction of	34518
Anoplasty for anal stricture	32123	malformation, excision of	45039,45042,45045
Anorectal carcinoma, excision of	32105	malformation, intracranial artery clipping of	39806
application of formalin	32212	malformation, intracranial, excision of	39803
examination, under GA	32171	malformation, laminectomy, radical excision of	40318
malformation, neonatal, laparotomy and colostomy	43822	shunt, declotting of	13106
malformation, paediatric, operations	43960,43963,43966	shunt, external, insertion/removal	34500,34506
sensation, measurement of	11830	Artery, anastomosis of, microvascular	45502
Anorectoplasty of anorectal malformation	43963,43966	bypass grafting, occlusive arterial disease	32700-32763
Antenatal cardiotocography (restriction)	16514	coeliac, decompression of	34142
care, independent of confinement	16500	coronary, bypass operations	38497,38500,38503,38498,38501,385
Antepartum haemorrhage, treatment of	16509	embolectomy of	33800,33803,33806
Anterior chamber, irrigation of blood from	42743	endarterectomy of	33500-33542
resection of rectum	32024,32025	ethmoidal, transorbital ligation of	41725
section of corpus callosum for epilepsy	40700	great, ligation/exploration, other	34103
synechiae, division of	42761	harvesting for coronary bypass	38496
vaginal repair	35576-35580	ligation/exploration not otherwise covered	34106
Antireflux operations	30527,30529,30530	major, of neck, ligation/exploration, other	34100
operation by fundoplasty	31464,31466	major, repair of wound of	33815-33839
Antrectomy and/or vagotomy	30497,30503	maxillary, transantral ligation of	41707
Antrobuccal fistula operation	41722	neck, reoperation for bleeding/thrombosis	33842
Antrostomy, radical	41710,41713	patch grafting to	33545,33548
Antrum, drainage of, through tooth socket	41719	popliteal, exploration for popliteal entrapment	34145
intranasal, operation on	41716	temporal, biopsy of	34109
maxillary, lavage of	41704	thrombectomy of	33803,33806
maxillary, proof puncture, lavage	41698,41701	Arthroctomy, hip	49309,49312
removal of foreign body from	41716	Arthrodesis, ankle	49712
Anus, dilatation of (Lord's procedure)	32153	elbow	49106
Aorta, anastomosis, congenital heart disease	38706,38709	finger/hand	46300,46303
thoracic, management of rupture/dissection	38572	foot	49815,49845
thoracic, repair/replacement procedures	38550-38571	hip	49306
Aortic bypass	32708,32710,32711	joint, other	50109

* Payable on attendance basis

Service	Item	Service	Item
knee	49509,49512,49545	consultant physician (not psychiatry)	110-131
sacro-iliac joint	49300	consultant psychiatrist	300-352
shoulder	48939,48942	consultant public health medicine	410-417
subtalar joint	50118	contact lenses	10801-10816
wrist	49200,49203	emergency - after hours	1,2,97,98
Arthroplasty, ankle	49715	emergency - after hours (11pm to 7am)	601,602,697,698
carpal bone	46324,46325	emergency physician	501-536
finger/hand	46306-46321	family group therapy	170,171,172
foot	49839,49842	focussed psychological strategies	2721,2723,2725,2727
hip	49309-49333,49346	general practitioner	1-51
joint, other	50127	general practitioner, emergency, after hours	1,2
knee	49518-49534	health assessments	700-706
shoulder	48915-48924	incentive items - PIP - general practitioner	2501-2559
temporo-mandibular joint	45758	incentive items - PIP - other non-preferred	2600-2677
wrist	49209	intensive care unit (specialist)	13870,13873
Arthroscopy, ankle	49700,49703	mental health process - 3 step	2704-2708
elbow	49118,49121	other non-specialist	52-98
hip	49360,49363,49366	other non-specialist, emergency, after hours	97,98
joint, other	50100,50102	post-operative	(see note T8.7)
knee	49557-49566	prolonged, lifesaving treatment	160-164
shoulder	48945-48960	public health physicians	410-417
wrist	49218-49227	specialist	104-108
Arthrotomy, ankle	49706	sports physicians	444-449
elbow	49100	Atticotomy	41533,41536
finger/hand	46327,46330	Audiogram	11309-11318
hip	49303	impedance	11324,11327,11330
joint, other	50103	Audiometry, brain stem evoked response	11300
knee	49500	non-determinate	11306
shoulder	48912	oto-acoustic emission audiometry	11332
wrist	49212	Auditory canal, external	41524
Artificial erection device, insertion of	37426,37429	- reconstruction of	
erection device, revision or removal of	37432	- reconstruction, congenital atresia	45662
insemination services	13203,13209,13221	- removal of foreign body, incision	41503
lens, insertion of	42701	canal external, blind sac closure	41564
lens, removal of	42704	canal stenosis, correction of, with meatoplasty	41521
lens, removal, replacement different lens	42707	meatus, external, removal of exostoses in	41518
lens, repositioning of, open operation	42704	meatus, internal, exploration	41599
urinary sphincter, insertion	37381,37384,37387	Augmentation mammoplasty	45524,45527,45528
urinary sphincter, revision/removal	37390	Aural polyp, removal of	41506
Arytenoidectomy with microlaryngoscopy	41867	Autoconjunctival transplant	42641
Aspiration biopsy, bone marrow	30087	Avulsion, penis, repair of	37411
biopsy, deep organ, imaging guided	30094	Axilla, lymph glands, excision of	30332
of bladder, needle	37041	lymph nodes, excision of	30336,30335
of breast cyst	*	Axillary hyperhidrosis, excision for	30180,30183
of haematoma	30216	to femoral bypass grafting	32715
of joint, other synovial cavity (restriction)	50124,50125	vessel, ligation/exploration, other	34103
of thoracic cavity	38400,38403	Axillofemoral graft, infected, excision of	34172
Assistance at operations	51300-51318	angiography, selected coronary	38215-38246
Assisted reproductive technologies	13200-13221		
Atherectomy, peripheral arterial	35312		B
Atresia, choanal, repair/correction	45645,45646	Baker's cyst, excision of	30114
external auditory canal, reconstruction	45662	Balloon catheter, right heart, insertion of	13818
Atrial chamber/s, operations for arrhythmia	38512,38515	intubation, gastro-oesophageal	13506
septal defect closure	38742	valvuloplasty or septostomy	38270
septectomy	38739	Bartholin's abscess, incision of	35520
Attendance, acupuncture	173-195	cyst or gland, marsupialisation of	35516,35517
Case Conference, Consultant Psychiatrist	855-866	cyst, excision of	35512,35513
anaesthetist, prior to anaesthesia	17603	Barton's fracture of radius, treatment of	47369,47372,47375
antenatal	16500	Basal cell carcinoma, removal of	31255-31295
care planning	720-728	Bat ear or similar deformity, correction of	45659
case conference - consultant Psychiatrist	855-866	Bicornuate uterus, plastic reconstruction for	35680
case conference, consultant physician	820-838	Bile duct, common, radical resection	30461,30463,30464
case conferencing	740-773	duct, common, repair of	30472
consultant occupational physician	385-388		

* Payable on attendance basis

Service	Item	Service	Item
duct, endoscopic stenting of	30491	sampling, fetal	16606
Biliary atresia, paediatric, portoenterostomy for	43978	transfusion	13703,13706
bypass	30460,30466,30467	transfusion, fetal	16609-16615
dilatation, endoscopic	30494	transfusion, paediatric/neonatal	13306,13309
drainage tube exchange, imaging guided	30451	volume estimation, nuclear	12500
manometry	30493	Bone, cysts, injection into or aspiration of	47900
stricture, repair of	30469	densitometry	12306-12321
Biopsy, aggressive bone/deep tissue tumour	50200	excision of, with melanoma	31340
biopsy, using ABBI	31539,31545	flap, infected, craniectomy for	39906
bone marrow	30081,30084,30087	graft to femur	48200,48203
breast	31530,31533,31548	graft to humerus	48212,48215
cervix, cone	35617,35618	graft to other bones	48239
cervix, punch	35608	graft to phalanx or metacarpal	46402,46405
conjunctiva	42676	graft to radius and ulna	48221
drill, lymph gland, deep tissue/organ	30078	graft to radius or ulna	48218,48224,48227
endometrial, for suspected malignancy	35620	graft to scaphoid	48230,48233,48236
endometrium	*	graft to spine	48642-48651
laparoscopic	30391	graft to tibia	48206,48209
liver	30409,30411	graft, harvesting of	47726,47729,47732
lung, percutaneous needle	38412	graft, with internal fixation	48242
lymph gland, muscle, other deep tissue/organ	30074,30075	lesion/s, removal, diaphyseal aclasia	50426
lymph node of neck	31420	marrow, administration of	13706
myocardial, by cardiac catheterisation	38275	marrow, aspiration biopsy of	30087
needle aspiration	*	marrow, harvesting of for transplantation	13700
percutaneous aspiration, deep organ	30094	marrow, in vitro processing/cryopreservation	13760
pleura	30090	tumour, benign, resection of	50230
prostate	37212,37215,37218	tumour, innocent, excision of	30241
punch, of synovial membrane	30087	tumour, malignant, operations for	50200-50239
rectum, full thickness	32096	Botulinum toxin injection into vocal cords	41869
renal (closed)	36561	Botulinus toxin injection for blepharospasm	42827
scalene node	30096	toxin injection for strabismus	42830
skin or mucous membrane	30071	Boutonniere deformity, reconstruction of	46444,46447
thyroid	*	Bowel, colectomy, total	32009-32021
vertebra, needle	30093	hemicolectomy	32000,32003,32006
Bladder, aspiration of, by needle	37041	ileostomy closure/reservoir	32060-32069
biopsy of, with cystoscopy	36836	large, resection of	32000,32003
catheterisation of	36800	large, subtotal colectomy	32004,32005
cystostomy or cystotomy	37008	perineal proctectomy	32047
diverticulum of, excision or obliteration	37020	rectosigmoidectomy (Hartmann's op)	32030
ectopic, 'turning-in' operation	37842	rectum and anus, resection	32039-32046
enlargement of, using intestine	37047	rectum, resection of	32024-32028
excision of	37000,37014	resection for enterocolitis stricture, neonatal	43834
exstrophy closure	37050	resection for jejunal atresia, neonatal	43810
exstrophy of, repair of	37842	restoration following Hartmann's op	32029,32033
neck reconstruction, prostatectomy	37210,37211	ruptured, repair or removal of	30375
neck resection, endoscopic	36854	small, intubation	30487,30488
repair of rupture	37004	small, resection of	30565,30566
stress incontinence, Stamey or similar	37043	small, strictureplasty	30564
stress incontinence, sling procedure	37042	Brachial plexus, exploration of	39333
stress incontinence, suprapubic procedure	37044	vessel, ligation/exploration, other	34106
transection, with re-anastomosis to trigone	37053	Brachycephaly, cranial vault reconstruction for	45785
tumour/s, diathermy/resection	36839,36845	Brachytherapy planning	15536
tumour/s, laser destruction with cystoscopy	36839	For prostate cancer	15338,15513,15539,37220
washout test of	11921	Brain stem evoked response audiometry	11300
Blepharospasm, injection of botulinus toxin	42827	stem tumour, craniotomy for removal	39709
Block, nerve, regional or field	(see nerve)	Branchial cyst, removal of	30286
Blood, administration of	13703,13706	fistula, removal of	30289
arterial, collection for pathology	13839,13842	Breast, biopsy, fine needle, imaging guided	31533
collection of, for transfusion	13709	abnormality detected by mammography	31506
collection of, in infants, for pathology	13312	benign lesion	31500,31503
dye - dilution indicator test	11715	biopsy of solid tumour, vacuum-assisted, image guided	31530
peripheral, invitro processing, cryopreservation	13760	central ducts, excision for benign condition	31557
pressure monitoring, indwelling catheter (ICU only)	13876	core biopsy of solid tumour or tissue	31548
retrograde admin for cardioplegia	38588	cyst, aspiration of	*

* Payable on attendance basis

Service	Item	Service	Item
exploration/drainage, operating theatre	31551	kidney, removal of	36540,36543
lesion, pre-op localisation, for ABBI	31542	renal, extraction of	36627-36648
lesion, pre-op localisation, imaging guided	31536	staghorn, nephrolithotomy and/or pyelolithotomy	36543
malignant tumour	31509,31512	sublingual/salivary gland duct, removal of	30265,30266
mammoplasty	45524,45527,45528	ureter, removal of	36549
manipulation tissue surrounding prosthesis	*	ureteric, endoscopic removal/manipulation	36857
mastectomy	(see mastectomy)	Caldwell-Luc operation	41710
microdochotomy	31554	Calf, decompression fasciotomy of	47975,47978,47981
nipple, accessory, excision of	31566	Caloric test of labyrinth(s)	11333,11336
prosthesis operations	45548-45554	Cancer of skin/mucous membrane, removal	30196-30205
ptosis, correction of (unilateral)	45556,45557	Cannulae, membrane oxygenation	38627
ptosis, correction of (bilateral)	45558	bypass	38627
reconstruction	45530-45542	ventricular assist	38627
silicone prosthesis, removal of	45555	Cannulation, arterial, for infusion chemotherapy	34524
tissue, accessory, excision of	31560	central vein	13318,13815
tumour site, re-excision	31515	central vein, subcutaneous tunnel	34527
Broad ligament cyst/tumour, excision/removal	35712-35717	coronary sinus, for admin of blood or crystalloid	38588
Brodie's abscess, operation for	43515	for cardiopulmonary bypass	38600,38603
Bronchial tree, intrathoracic operation on, other	38456	for retrograde cerebral perfusion	38577
Bronchoscopy, as an independent procedure	41889	intra-abdominal vessel, for chemotherapy	34521
with biopsy or other procedure	41892	peripheral arterial	35317-35321
with dilatation of tracheal stricture	41904	peripheral venous	35317,35319,35320
with transbronchial lung biopsy	41898	pulmonary artery	13818
Bronchspirometry	11500	umbilical artery	13303
Bronchus, dilatation of stricture and stent insertion	41905	umbilical/scalp vein in neonate	13300
operations on	41889,41892,41895	Canthoplasty	42590
removal of foreign body in	41895	Capsule, posterior, needling of	42737
Broviac catheter, insertion of, for chemotherapy	34527,34528	Capsulectomy	42719,42722,42731
catheter, removal of	34530	of finger joints	46336
Bubonocele operation	30612,30614	Capsulotomy, laser	42788,42789
Bunion, excision of	47933	other than laser	42734
Burch colposuspension	37044	Carbolisation of eye	*
Burns, dressing of (not involving grafting)	30003-30014	Carbon dioxide laser resurfacing, face or neck	45025,45026
excision of under GA (not involving grafting)	30017,30020	dioxide output, estimation of	11503
free grafting	45406-45494	labelled urea breath test	12533
scars, excision of	45519	Carbuncle, incision and drainage, with GA	30223
Burr-hole craniotomy, intracranial haemorrhage	39600	Carcinoma	(see tumour)
placement of intracranial electrodes	40709	Cardiac by-pass, whole body perfusion	22060
single, preparatory to ventricular puncture	39012	catheterisation	38200-38218
Bursa, incision of	*	catheterisation - for myocardial biopsy	38275
large, excision of	30110,30111	deep hypothermic circulatory arrest	22075
semimembranosus, excision of	30114	electrophysiological studies	38209,38212,38213
small, excision of	30106,30107	operation (intrathoracic), other	38456
Burst abdomen, repair of	30403	pacemaker, insertion/replacement	38281
Bypass, extracranial to intracranial	39818	rhythm, restoration, electrical stimulation	13400
graft, infected, of extremities, excision of	34175	surgery, for congenital heart disease	38700-38766
graft, infected, of neck, excision of	34157	surgery, re-operation via median sternotomy	38640
graft, infected, of trunk, excision of	34169	tumour, excision of	38670-38680
grafting for aneurysm	33050,33055	Cardiopexy, antireflux operation	30530
grafting, arterial, for occlusive arterial disease	32700-32763	Cardioplegia, retrograde administration of	22070
grafting, cross leg, saphenous to iliac or femoral vein	34806	Cardiopulmonary bypass, cannulation for	38600,38603
		support procedures	13815-13857
C		Cardiotocography, antenatal (restriction)	16514
C-13 or C-14 urea breath test	12533	Cardioversion	13400
Caecostomy, involving laparotomy	30375	Care planning	720-728
closure of	30562	Carotid artery, aneurysm, graft replacement	33100
Caesarean section	16520,16522	artery, internal, transection/resection	32703
Calcaneal spur, of foot, excision of	49818	body tumour, resection of	34148,34151,34154
Calcanean bursa, excision of	30110,30111	cavernous fistula, obliteration of	39815
Calcaneum fracture, treatment of	47606-47618	vessels, examination of	11618,11621,11624
Calculus, biliary, extraction of	30454-30458	Carpal bone, replacement arthroplasty	46324,46325
biliary/renal tract, extraction of	30450	ligament, transverse, division of	39331
bladder, removal of	36863	resection arthroplasty	46325
		saphoid, fracture, treatment of	47354,47357

* Payable on attendance basis

Service	Item	Service	Item
tunnel release	39331	oesophagectomy	30294
Carpometacarpal joint, arthrodesis of	46303	oesophagostomy, closure or plastic repair of	30293
joint, dislocation, treatment of	47030,47033	re-exploration for hyperparathyroidism	30317
joint, synovectomy of	46342	rib, removal of	34139
Carpus dislocation, treatment of	47030,47033	sympathectomy	35003,35006
fracture, treatment of	47348,47351	Cervix, amputation or repair of	35617,35618
operation on, acute osteomyelitis	43503,46462	cauterisation of, other than by chemical means	35608
operation on, chronic osteomyelitis	43512,46462	colposcopic examination of	35614
osteectomy/osteotomy of	48406,48409	colposcopy with biopsy and diathermy	35646
Cartilage, tarsal, excision of	42578	cone biopsy of	35617,35618
excision of, with melanoma	31340	diathermy of	35608,35646
Caruncle, urethral, cauterisation of	35523	electrocoagulation diathermy	35644,35645
urethral, excision of	35526,35527	ionisation of	35608
Case conferencing	740-773	large loop excision	35647,35648
Cataract, juvenile, removal of	42716	laser therapy (restriction applies)	35539,35542,35545
surgery	42702	punch biopsy	35608
Catheter, peritoneal insertion and fixation	13109	purse string ligation	16511
epidural, insertion of	39140	removal of polyp from	35611
placement of catheters and injection of opaque material	38243	removal of purse string ligature	16512
tenckhoff peritoneal dialysis, removal of	13110	repair of extensive laceration/s	16571
Catheterisation, bladder, independent procedure	36800	repair of, not otherwise covered	35617,35618
blood pressure monitoring	13876	residual stump, removal of, abdominal approach	35612
cardiac	38200-38218	residual stump, removal of, vaginal approach	35613
central vein	13318,13319,13815	Chalazion, extirpation of	42575
central vein, subcutaneous tunnel	34527,34528	Chemical peel, full face	45019,45020
eustachian tube	41755	Chemotherapy	13915-13936
frontal sinus	41740	device for drug delivery, loading of	13939,13942,13945
intracranial, for pressure monitoring	13830	device, insertion, central vein catheterisation	34527,34528
peripheral arterial	35317-35321	device, removal of	34530
peripheral venous	35317,35319,35320	infusion, cannulation for	34521,34524
peritoneal, for dialysis	13109,13110	Chest, or limb, decompression escharotomy	45054
pulmonary artery	13818	Chloasma, full face chemical peel	45019,45020
right heart balloon	13818	Choanal atresia, repair/correction	45645,45646
umbilical artery	13303	Cholangiogram, percutaneous transhepatic	30440
umbilical or scalp vein in a neonate	13300	Cholangiography, operative	30439
ureteric, with cystoscopy	36824	Cholangiopancreatography	30484
Caudal infusion/injection	(see Intrathecal)	Cholecystectomy	30443-30449
Cauterisation, angioma (restriction applies)	45027	Cholecystoduodenostomy	30460,31472
cervix	35608	Cholecystoenterostomy	30460,31472
perforation of tympanum	41641	Cholecystostomy	30375
septum/turbinates/pharynx	41674	Choledochal cyst, resection of	43972,43975
tarsus, for ectropian/entropian	42581	Choledochoduodenostomy	30460,30461
urethra or urethral caruncle	35523	Choledochenterostomy	30460,30461
Cautery, conjunctiva, including treatment of pannus	42677	Choledochogastrostomy	30461
nasal, for arrest of haemorrhage	41677	Choledochojejunostomy	30460,30461
Cavernous sinus, tumour or vascular lesion, excision	39660	Choledochoscopy	30442,30452
Cavopulmonary shunt, creation of	38733,38736	Choledochotomy	30454,30455,30457
Cellulitis, incision with drainage, under GA	30223	Chondro-cutaneous or chondro-mucosal graft	45656
Central cannulation for cardiopulmonary bypass	38600	Chondroplasty of knee	49503,49506
nervous system evoked responses	11024,11027	Chordee, correction of	37417
vein catheterisation	13318,13319,13815	Chorionic villus sampling	16603
vein catheterisation, via subcutaneous tunnel	34527,34528	Chymopapain (Discase), intradiscal injection of	40336
Cerebello-pontine angle tumour	41575-41579	Cicatricial flexion/extension contracture, joint, correction	50112
- retromastoid removal of	41575-41579	Ciliary body and/or iris, excision of tumour	42767
- translabrynthine removal	41575-41579	Circulatory support device, management of	13851,13854
- transmastoid removal	41575-41579	support procedures	38600-38624
Cerebral palsy, hips or knees, application of cast under GA	50390	Circumcision	30653-30660
perfusion, retrograde, cannulation for	38577	arrest of post-operative haemorrhage	30663
tumour, craniotomy for removal	39712	- with GA	
ventricle, puncture of	39006	- without GA	*
Cerebrospinal fluid drain, lumbar, insertion of	40018	Cisternal puncture	39003
fluid reservoir, insertion of	39018	shunt diversion, insertion of	40003
Cervical decompression of spinal cord	40331-40335	shunt, revision or removal of	40009
discectomy (anterior), without fusion	40333	Clavicle, dislocation, treatment of	47003,47006

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Service	Item	Service	Item
fracture, treatment of	47462,47465	Contour reconstruction, insertion of foreign implant	45051
operation for acute osteomyelitis	43503	restoration of face, autologous bone/cartilage graft	45647
operation for chronic osteomyelitis	43512	Contraceptive device, intra-uterine, introduction of	35503
osteotomy/osteotomy	48406,48409	device, intra-uterine, removal under GA	35506
Claw toe, correction of	49848	Contracted socket, reconstruction	42527
Cleft lip, operations for	45677-45704	Contracture, cicatricial flexion/extension of joint, correction	50112
palate, correction of	45707,45710,45713	Dupuytren's, subcutaneous fasciotomy for	46366
Clitoris, amputation of, medically indicated	35530	flexor/extensor, digits of hand, correction of	46492
Clitoroplasty, reduction, ambiguous genitalia	37845,37848	Cordotomy, laminectomy for	39124
Clival tumour, removal of	39653-39658	percutaneous	39121
Cloaca, persistent, correction of	43969	Cornea, conjunctival graft over	42638
Cloacal exstrophy, neonatal, operation for	43882	epithelial debridement for corneal ulcer/erosion	42650
Club hand, radial, centralisation/radialisation	50399	epithelial debridement for keratoplasty	42651
Coccyx, excision of	30672	removal of imbedded foreign body	42644
Cochlear implant, insertion with mastoidectomy	41617	removal of superficial foreign body	30061
tests	11318,11321	transplantation of	42653,42656,42659
Cochleotomy, or repair of round window	41614	Corneal blood vessels, laser coagulation of	42797
Coeliac artery, decompression of	34142	incisions, non penetrating	42674
Coliectomy, subtotal, of large intestine	32004,32005	keratoplasty, epithelial debridement for	42651
total, for Hirschsprung's, paediatric	43996	perforations, sealing of	42635
total, with excision rectum/anastomosis	32051,32054,32057	scars, excision of	42647
total, with excision rectum/ileostomy	32015,32018,32021	suture, running, manipulation of	42667
total, with ileo-rectal anastomosis	32012	sutures, removal of	42668
total, with ileostomy	32009	ulcer, epithelial debridement of cornea for	42650
Colles' fracture of radius, treatment of	47369,47372,47375	ulcer, ionisation of	*
Colonic atresia, neonatal, laparotomy for	43816	Coronary artery bypass operations	38497,38500,38503,38498,38501,
lavage, total, intra-operative	32186	angiography, selective	38215-38246
reservoir, construction of	32029	artery bypass vein graft, dissection	38637
Colonoscopy, fiberoptic	32084-32093	endarterectomy, open operation	38505
Colorectal strictures, endoscopic dilatation of	32094	Corpus callosum, anterior section of, for epilepsy	40700
Colostomy, closure of	30562	Corticectomy, for epilepsy	40703
entero-	30515	Corticolysis of lens material	42791,42792
lavage of	*	Costo-transverse joint, injection into	39013
refashioning of	30563	Counterpulsation, intra-aortic balloon, management	13845,13848
with laparotomy	30375	Cranial nerve, intracranial decompression of	39112
with laparotomy, neonatal anorectal malformation	43822	shunt diversion, insertion of	40003
Colotomy, with laparotomy	30375	shunt, revision or removal of	40009
Colour discrimination test, Farnsworth Munsell	*	vault reconstruction	45785
Colpoperineorrhaphy	35576,35580	Craniectomy and removal of haematoma	39603
Colpopexy	35590	for osteomyelitis/removal infected bone	39906
Colpoplasty	35584	Craniocervical junction lesion, transoral approach for	40315
Colposcopy, using Hinselmann-type instrument	35614	Craniopharyngioma, craniotomy for removal of	39712
with other procedures	35644-35647	Cranioplasty and repair of fractured skull	39615
Colpotomy	35572	reconstructive	40600
Composite graft to nose, ear or eyelid	45656	Craniostenosis, operations for	40115,40118
Computerised perimetry	11221-11225	Craniotomy and tumour removal	39709,39712
Condylectomy	45611,48406,48424	burr-hole for intracranial haemorrhage	39600
of mandible	45611	for arachnoidal cyst	39718
Cone biopsy of cervix	35617,35618	for hydromyelia (with laminectomy)	40342
Confinement	16515-16525	for reopening post-op for haemorrhage/swelling	39721
Congenital absence of vagina, reconstruction for	35565	Cricopharyngeal myotomy	41776
atresia, auditory canal reconstruction	45662	Cricothyrostomy	41884
heart disease, operations for	38700-38766	Cruciate ligaments, reconstruction/repair	49536,49539,49542
Conjunctiva, cautery of	42677	Cryocautery of skin lesions	30189,30192,30195
biopsy of	42676	Cryoneurotomy of peripheral nerves	39323
cryotherapy to	42680	Cryosurgery to haemorrhoids with rubber band ligation	32135
removal of tumour from	(see tumour ,other)	Cryotherapy for detached retina	42773
Conjunctival cysts, removal of	42683	for trichiasis	42587
graft over cornea	42638	hepatic, destruction of liver tumours	30419
lacerations not involving sclera	30032	of retina, with vitrectomy	42728
peritomy	42632	to nose, for haemorrhage	41680
Conjunctivorhinostomy	42629	to retina, independent procedure	42818
Consultation	(see attendances)	Crystalloid, retrograde admin for cardioplegia	38588
Contact lenses, attendances	10801-10816	Curetteage, for evacuation of gravid uterus	35643

* Payable on attendance basis

Service	Item	Service	Item
uterus (D and C)	35639,35640	suprapubic, change of tube	*
Cutaneous neoplastic lesions, treatment of	30195	Cystotomy, suprapubic	37008,37011
nerve, nerve graft to	39318	Cytotoxic agent, instillation into body cavity	13948
nerve, repair of	39300,39303		
ureterostomy, closure of	36621	D	
vesical fistula, operation for	37023		
vesicostomy, establishment of	37026	D and C	35639,35640
Cyclodestructive procedures for treatment of glaucoma	42770,42771	Dacryocystectomy	42596
Cyst, arachnoidal, craniotomy for	39718	Dacryocystorhinostomy	42623,42626
Baker's, excision of	30114	Dark Adaptometry	11211
Bartholin's, cautery destruction of	35516,35517	Debridement of contaminated wound	30023
Bartholin's, excision of	35512,35513	of tissue, ischaemic limb	35100,35103
Bartholin's, marsupialisation of	35516,35517	Debulking operation, gynaecological malignancy	35720
bone, injection into or aspiration of	47900	Decompression fasciotomy, calf/forearm	47975,47978,47981
brain, operations for	39703	fasciotomy, hand	47981
branchial, removal of	30286	of Arnold-Chiari malformation	40106
breast, aspiration of	*	of facial nerve, mastoid portion	41569
broad ligament, excision of	35712-35717	of intracranial tumour	39706
bronchogenic, thoracotomy and excision	43912	operation for priapism	37393
choledochal, resection of	43972,43975	subtemporal	40015
enterogenous, thoracotomy and excision	43912	Deep organ, percutaneous aspiration biopsy	30094
epididymal, removal of	37601	tissue or organ, biopsy of	30074,30075,30078
fimbrial, excision of	35712-35717	Defibrillator generator, insertion/replacement	38524
hydatid, liver, treatment of	30434-30438	insertion of patches for	38521
hydatid, lungs, enucleation of	38424	Delorme procedure	32111
intracranial, needling and drainage of	39703	Dermabrasion	45021,45024
kidney, removal from	36558	Dermo-fat or fascia graft	45018
liver, laparoscopic marsupialisation	30416,30417	Dermoid, excision of	(see tumour , other)
mucous, of mouth, removal	30282,30283	nasal, excision of	41729
other, removal of	31200-31240	orbital, excision of	42574
ovarian, aspiration of	35518	periorbital, excision of	42573
ovarian, excision of, with laparotomy	35712-35717	Detached retina, diathermy/cryotherapy	42773
pancreatic, anastomosis	30586,30587	retina, removal of silicone band	42812
parovarian, excision of, with laparotomy	35712-35717	retina, resection/buckling/revision	42776
pharyngeal, removal of	41813	Dialysis, peritoneal	13112
pilonidal, excision of	30675,30676	peritoneal, supervision in hospital	13100,13103
renal, excision of	36558	Diaphragm, plication of for eventration	43915
skin/subcutaneous/mucous membrane, removal of	31200-31240	Diaphragmatic hernia, neonatal, repair of	43837,43840
tarsal, extirpation of	42575	hernia, repair of	30600,30601
thyroglossal, removal of	30313,30314	hernia, simple closure of	30387
vaginal, excision of	35557	Diaphyseal aclasia, removal of lesion/s from bone	50426
vallecular, removal of	41813	Diastematomyelia, tethered cord, release of	40112
Cystadenomatoid malformation, neonatal, thoracotomy	43861	Diathermy of bladder tumours	36839,36845
Cystocele, repair of	35576,35580	cervix	35608,35646
Cystometry	11903	detached retina	42773
with other procedures	11912,11915,11918,11917	electrocoagulation, of cervix	35644,35645
Cystoscopy, with	36836	palmar or plantar wart	30186
- biopsy of bladder		perforation of tympanum	41641
- controlled hydrodilatation of bladder	36827	pharynx	41674
- diathermy or resection of bladder tumour/s	36839,36845	rectal polyps with sigmoidoscopy	32078
- endoscopic incision/resection	36825,36854	salivary gland duct	30262
- injection into bladder wall	36851	septum	41674
- insertion of ureteric stent, or brush biopsy	36821	starburst vessels, head or neck	30213,30214
- insertion of urethral prosthesis	36811	telangiectases, head or neck	30213,30214
- laser destruction of bladder tumours	36839	turbines	41674
- lavage of blood clots from bladder	36842	urethra	37318
- removal of foreign body	36833	Diffusing capacity	11503
- resection of ureterocele	36848	Digit, amputation of	46464-46480
- ureteric catheterisation	36818,36824	distal, excision of ganglion/mucous cyst	46495
- ureteric meatotomy	36830	extra, amputation of	46464
- urethroscopy with/without urethral dilatation	36812	flexor/extensor contracture, correction of	46492
- without litholapaxy	36863	or ray, transposition/transfer, vascular pedicle	46507
- without urethroscopy	36815	synovectomy of tendon/s	46348-46360
Cystostomy, suprapubic	37008	transposition/transfer, vascular pedicle	46507

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Service	Item	Service	Item
Digital nail, toe, removal of	47904,47906	toilet, using operating microscope	41647
nerve, nerve graft to	39318	ventilating tube, removal	*
nerve, repair of	39300,39303	Eclampsia, treatment of	16509
temperature, measurement of	11615	Ectopic bladder, 'turning-in' operation	37842
Direct flap repair	45209-45224	pregnancy, removal of	35676,35677,35678
Disarticulation, of limb	(see amputation)	pregnancy, ultrasound guided needling and injection	35674
Disc, intervertebral, laminectomy for removal	40300	Ectropion, correction of	45626
intervertebral, microsurgical discectomy of	40301	tarsal cauterisation for	42581
lesion, recurrent, laminectomy for	40303	Elbow, arthrodesis of	49106
Discectomy, cervical (anterior), without fusion	40333	arthroscopic surgery of	49121
microsurgical, of intervertebral disc/s	40301	arthroscopy of, diagnostic	49118
percutaneous lumbar	48636	arthrotomy of	49100
Disimpaction of faeces under GA	32153	dislocation, treatment of	47018,47021
Dislocations, treatment of	(see body part)	flexorplasty/tendon transfer to restore function	50405
Dissection, lymph nodes of neck	31423-31438	ligamentous stabilisation of	49103
Diverticulum, bladder, excision/obliteration	37020	radial head, replacement of	49112
Meckel's, removal of	30375	total replacement of	49115
urethral, excision of	37372	total synovectomy of	49109
Dohleman's operation	41773	Electrical stimulation, maximal perineal	*
Domiciliary Medication Management Review	900	stimulation, restoration cardiac rhythm	13400
Donald-Fothergill operation	35584	Electrocardiography	11700-11713
Donor haemapheresis	13755	Electrocochleography	11303,11304
Doppler recordings, carotid vessels	11618,11621,11624	Electroconvulsive therapy	14224
recordings, peripheral vessels	11603-11612	Electrocorticography	11009
Double vagina, excision of septum	35566	Electrode(s), epidural, insertion by laminectomy	39139
Drez lesion, operation for	39124	epidural, percutaneous insertion of	39130
Drill biopsy of lymph gland/deep tissue/organ	30078	epidural, percutaneous, management of	39131
Drug delivery device, loading of	13939,13942,13945	graciloplasty, insertion of	32206
Duct, salivary gland, diathermy/dilatation	30262	intracranial placement	40709,40712
salivary gland, major, transposition of	41910	myocardial, permanent, insertion, thoracotomy	38470
salivary gland, marsupialisation	30265,30266	pacemaker, permanent, insertion, sub-xiphoid	38473
salivary gland, meatotomy	30265,30266	transvenous, insertion of	38256,38284
salivary gland, removal of calculus	30265,30266	Electrodiagnosis, neuromuscular	11012-11021
Ducts submandibular, removal of	30255	Electroencephalography (E.E.G)	11000,11003,11006
Duodenal atresia, duodeno-duodenostomy/jejunostomy	43807	Electrolysis epilation, for trichiasis	42587
intubation	30487,30488	Electromyography (E.M.G.)	11012,11021,11833
stenosis, duodeno-duodenostomy/jejunostomy	43807	Electroneurography of facial nerve	11015
ulcer, perforated, laparotomy and suture	30375	Electronystagmography (E.N.G.)	11339
Duodenoduodenostomy for duodenal atresia/stenosis	43807	Electrooculography	11205
Duodenojejunostomy for duodenal atresia/stenosis	43807	Electrophysiological studies, cardiac	38209,38212,38213
Duodenoscopy	30473,30476,30478	Electroretinography	11205,11210,11204
Dupuytren's contracture, operations for	46366-46393	Embolectomy	33803,33806
Dysthyroid eye disease, decompression of orbit	42545	Embolus, removal from artery of neck	33800
		Emergency, after hours	1,2,97,98
E		Emergency, after hours (11pm to 7am)	601,602,697,698
E.C.G.	11700-11713	Emphysema, lobar, neonatal, thoracotomy & lung resection	43861
E.C.T.	14224	Empyema, intercostal drainage of	38409,38410
E.E.G.	11000,11003,11006	radical operation for	38415
E.M.G.	11012,11021,11833	Enbloc resection of tumour	50212-50227
E.N.G.	11339	Encephalocoele, excision and closure of	40109
ESWL	36546	Enderterectomy	33500-33542
Ear, composite graft to	45656	coronary, open operation	38505
drum perforation, excision of rim	41644	to prepare bypass site for anastomosis	33554
external, complex total reconstruction of	45660,45661	Endobronchial tumour, endoscopic laser resection	41901
full thickness laceration, repair of	30052	Endocarditis, operative management of	38493
full thickness wedge excision of	45665	Endocrine tumour, exploration of	30578,30580,30581
lop, bat or similar deformity, correction of	45659	Endolymphatic sac, transmastoid decompression	41590
middle, clearance of	41635,41638	Endometrial biopsy for suspected malignancy	35620
middle, exploration of	41629	Endometriosis, laparoscopic ablation	35638
middle, insertion of tube for drainage of	41632	Laparoscopic resection of	35641
middle, operation for abscess or inflammation of	41626	Endometrium, ablation of, endoscopic	35622
removal of foreign body from	41500,41503	biopsy of	*
syringe of	*	biopsy of for suspected malignancy	35620
		biopsy of with hysteroscopy	35630

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Service	Item	Service	Item
endoscopic examination and ablation by microwave	35616	Evacuation of retained products of conception	16564
Endoscopic biliary dilatation	30494	Eventration, plication of diaphragm for	43915
cholangio-pancreatography	30484	Evisceration of globe of eye	42512,42515
dilatation of colorectal strictures	32094	Evoked response audiometry, brain stem	11300
examination of intestinal conduit/reservoir	36860	responses, central nervous system	11024,11027
examination of small bowel	30569,32095	Exenteration of orbit of eye	42536
gastrostomy, percutaneous	30481,30482	Exomphalos, neonatal, operations for	43870,43873
incision/resection, external sphincter/bladder neck	36854	Exostoses in external auditory meatus, removal	41518
laser ablation of prostate	37207,37208	Exostosis, excision of	47933,47936
laser resection of endobronchial tumours	41901	Exstrophy, cloacal, neonatal, operation for	43882
laser therapy of gastrointestinal tract	30479	of bladder, closure	37050
manipulation/extraction of ureteric calculus	36857	of bladder, repair of	37842
prostatectomy	37203,37206	Extensor tendon of hand or wrist, repair of	46420,46423
resection of pharyngeal pouch	41773	tendon of hand, tenolysis of	46450
sphincterotomy	30485	tendon, synovectomy of	46339
stenting of bile duct	30491	External auditory canal, reconstruction	41524,45662
Endoscopy with balloon dilatation gastric stricture	30475	auditory meatus, removal of exostoses	41518
Enterocoele, repair of	35590,35593	cephalic version	16501
Enterocolitis, acute neonatal necrotising, laparotomy	43828,43831	ear, complex total reconstruction of	45660,45661
necrotising stricture, bowel resection	43834	fixation, orthopaedic, removal	47948,47951
Enterocolostomy	30515	stent, application	34824-34833
Enterocutaneous fistula, radical repair of	30382	External cephalic version	16501
Enterointerostomy	30515	Extra digit, amputation of	46464
Enterostomy, closure of	30562	Extracardiac conduit, insertion/replacement	38757,38760
with laparotomy	30375	Extracorporeal shock wave lithotripsy	36546
Enterotomy, intra-operative, for endoscopy	30568	Extracranial to intracranial bypass	39818,39821
Entropion, correction of	45626	Extradural tumour or abscess, laminectomy for	40309
repair of	42866	Eye, capsulotomy, laser	42788,42789
Enucleation of eye	42506,42509	carbolisation of	*
hydatid cysts of lung	38424	coagulation, laser, of corneal/scleral blood vessels	42797
Epicondylitis, open operation for	47903	conjunctiva, cautery of	42677
Epicutaneous patch testing	12012-12021	conjunctival graft	42638
Epididymal cyst, excision of	37601	corticolysis, laser, of lens material	42791,42792
Epididymectomy	37613	dermoid, excision of	42573,42574
Epidural blood patch	18233	division of suture, laser	42794
catheter, insertion of	39140	enucleation of	42506,42509,42510
electrode, insertion	39130,39139	fibrinolysis	42791,42792
electrode, management, adjustment etc.	39131	foreign body in cornea or sclera, removal of	42644
implant, removal of	39136	foreign body in, removal of	42560-42569
infusion/injection	(see Group T7)	foreign body in, superficial, removal of	30061
stimulator, revision of	39133	globe of, evisceration of	42512
Epigastric hernia, repair of	30616-30621	investigation of ocular surface dysplasia	11235
Epilation electrolysis, for trichiasis	42587	iridotomy, laser	42785,42786
Epilepsy, operations for	40700-40712	iris tumour, laser photocoagulation	42806
Epiphyseal arrest	48500-48509	orbit, insert/remove implant	42518
plate, prevention of closure	48512	paracentesis	42734
Epiphysiodesis, femur/fibula/tibia	48500,48503,48506	phototherapeutic keratectomy, laser	42810
staple arrest of hemi-epiphysis	48509	pinguecula, surgical excision	42689
Epiphysiolysis, to prevent closure of plate	48512	trabeculoplasty, laser	42782
Epispadias, repair of	37836,37839,37842	vitrealysis, laser, of lens material	42791
Epistaxis, treatment of	41656,41677,41680	Eyeball, repair of perforating wound	42551,42554,42557
Epithelial debridement for corneal ulcer/erosion	42650	Eyeblink, elevation of	42872
debridement/eliminating band keratoplasty	42651	Eyelashes, ingrowing, operation for	45626
Ergometry, with electrocardiography	11712	Eyelid closure in facial nerve paralysis, implant insertion	42869
Erythrocyte radioactive uptake survival time	12503	composite graft to	45656
screening test, volume Cr51	12500	ectropion or entropion, correction of	45626
Escharotomy, decompression, limb or chest		full thickness laceration, repair of	30052
Ethmoidal artery, transorbital ligation of	41725	full thickness wedge excision of	45665
sinuses, operation on	41737,41749	grafting for symblepharon	45629
Ethmoidectomy, fronto-nasal	41731	ptosis, correction of	45623
fronto-radical	41734	reconstruction of, whole thickness	45614,45671,45674
transantral, with radical antrostomy	41713	reduction of	45617,45620
Eustachian tube, catheterisation of	41755	removal of cyst from	42575
obliteration of	41564	tarsorrhaphy	42584

* Payable on attendance basis

Service	Item	Service	Item
upper recession of	42863	Fissure in ano, operation for	32150
F		Fistula, alimentary, repair of	35596
Face, repair of complex fractures	45753,45754	anal, excision/repair	32159-32166
chemical peel	45019,45020	antrobuccol, operation for	41722
Facet joint denervation by percutaneous neurotomy	39118	aorto-duodenal, repair of	34160,34163,34166
Facial, nerve, decompression of	41569	arteriovenous, dissection, ligation	34112,34115,34118
nerve palsy, excision of tissue for	45581	arteriovenous, dissection, repair	34121-34130
nerve paralysis, plastic operation for	45575,45578	arteriovenous, ligation cervical vessel/s	39812
scar, revision of (restriction applies)	45506,45512	branchial, removal of	30289
Facio-hypoglossal/accessory nerve, anastomosis of	39503	carotid-cavernous, obliteration of	39815
Fallopian tubes, catheterisation, with hysteroscopy	35633	cutaneous, salivary gland, repair of	30269
tubes, Rubin test for patency	35706	enterocutaneous, radical resection	30382
tubes, hydrotubation of	35703,35709	genito-urinary, repair	35596
tubes, implantation of, into uterus	35694,35697	in ano, subcutaneous, excision of	32156
tubes, microsurgical anastomosis	35700	oro-antral, plastic closure of	41722
tubes, sterilisation	35687,35688	parotid gland, repair of	30269
tubes, sterilisation with Caesarean section	35691	sacrococcygeal, excision of	30675,30676
Fallopscopy, unilateral/bilateral	35710	thyroglossal, radical removal of	30314
Family group psychotherapy	342,344,346	tracheo-oesophageal, division and repair	43900
group therapy	170,171,172	urethral, closure of	37833
Farnsworth Munsell colour discrimination test	*	urethro-rectal	37336
Fascia, deep, repair of, for herniated muscle	30238	urethro-vaginal	37333
graft	45018	vesical, cutaneous, operation for	37023
Fasciectomy, for Dupuytren's Contracture	46369-46393	vesico-intestinal, closure of	37038
Fasciotomy, forearm or calf	47975,47978,47981	vesico-vaginal, closure of	37029
interosseous muscle space of hand	47981	wound, review under GA, independent	32168
muscle	30226	Fixation, external, removal of	47948,47951
plantar, radical	49854	internal, of spine	48678-48690
subcutaneous, Dupuytren's contracture	46366	Flap, Abbe	45701,45704
Femoral hernia, repair of	30609,30612,30614	direct, indirect or local, revision of	45239
vein puncture in infants, blood collection	13312	free tissue transfer, revision of	45496-45499
vessel, ligation/exploration, other	34103	indirect	45227-45236
Femoro-femoral crossover bypass grafting	32718	myocutaneous, delay of	45015
graft, infected, excision of	34172	myocutaneous, for breast reconstruction	45530
Femur, bone graft to	48200,48203	neurovascular island	45563,46504
congenital deficiency, treatment of	50411,50414	pharyngeal, for velo-pharyngeal incompetence	45716
drill decompression of head/neck or both	47982	repair, direct	45209-45224
epiphyseodesis	48500,48506	repair, local, single stage	45200,45203,45206
fracture, treatment of	47516-47537,49336	repair, muscle, single stage	45000-45012
operation on, for osteomyelitis	43506,43515	Flexor tendon, hand, repair of	46426-46435
osteectomy/osteotomy	48424,48427	tendon pulley, reconstruction	46411
Fibreoptic bronchoscopy	41898	tendon sheath, finger or thumb, open operation	46522
colonoscopy	32084-32093	tendon, hand, tenolysis of	46453
Fibrinolysis	42791,42792	tendon, hand/wrist, synovectomy of	46339
Fibroma, removal of (see tumour,other)		tendon, wrist, repair of	46426,46429
Fibula, congenital deficiency, transfer fibula to tibia	50423	tendon/s, digit, synovectomy of	46348-46360
epiphyseodesis	48503,48506	Flexorplasty to restore elbow function	50405
fracture, treatment of	47576	Flow volume loops	11512
operation on, for osteomyelitis	43503,43512	Fluid Filled Cavity, drainage of	16624
osteectomy/osteotomy	48406,48409	Fluid balance, supervision of	*
Field block (see nerve)		Foetal blood sampling	
Filtering and allied operations for glaucoma	42746	fluid filled cavity, drainage of	16624
Fimbrial cyst, removal of	35712-35717	intraoperative blood transfusion	
Finger, amputation of	46465-46483	intravascular blood transfusion	
digital nail, removal of	46513,46516	Foeto-amniotic shunt, insertion of	16627
dislocation, treatment of	47036,47039	Foot, amputation or disarticulation of	44359,44361,44364
flexor tendon sheath, open operation	46522	and ankle, tibialis tendon transfer	50339,50342
fracture, treatment of	47300-47333	arthrodesis of	49815,49845
ingrowing nail, resection of	46528,46531	calcaneal spur, excision of	49818
mallet, fixation/repair	46438,46441	claw or hammer toe, correction of	49848,49851
percutaneous tenotomy of	46456	hallux valgus or hallux rigidus, correction of	49821-49842
trigger, correction of	46363	metatarso-phalangeal joint, replacement of	49857
		metatarso-phalangeal joint, synovectomy of	49860,49863
		neurectomy for plantar digital neuritis	49866

* Payable on attendance basis

Service	Item	Service	Item
paronychia of, pulp space infection, incision	47912	Gangrenous tissue, debridement of	35100,35103
radical plantar fasciotomy or fasciectomy of	49854	Gartner duct cyst, removal of	35557
tendon of, repair of	49800,49803	Gastrectomy, partial	30518
tendon or ligament transplantation of	49812	sub-total, radical, for carcinoma	30523
tenotomy of	49806,49809	total	30521,30524,30526
tibialis tendon transfer	50339,50342	Gastric by-pass for obesity	30512
For anaesthesia	20100-25205	band, in association with implanted reservoir	14215,31441
Foramen Magnum, tumour or vascular lesion, excision	39662	cooling (by lavage with ice-cold water)	*
Forearm, amputation or disarticulation of	44328	hypothermia	13500,13503
decompression fasciotomy of	47975,47978,47981	lavage in the treatment of ingested poison	14200
fracture, treatment of	47378-47393	reconstruction with oesophagectomy	30535
radial aplasia/dysplasia, centralisation/radialisation	50399	reduction for obesity	30511
Foreign body, antrum, removal of	41716	stricture, endoscopy with balloon dilatation	30475
bladder, cystoscopic removal of	36833	tumour, removal of	30520
bronchus, removal of	41895	ulcer, perforated, laparotomy with suture	30375
cornea or sclera, imbedded, removal of	42644	Gastro-camera investigation	30473
cornea or sclera, superficial, removal of	30061	Gastro-oesophageal balloon intubation	13506
ear, removal of	41500,41503	reflux, clinical assessment of	11810
implant, contour reconstruction, insertion	45051	reflux, operations for	43951,43954,43957
intra-ocular, removal of	42560-42569	Gastroduodenal stricture, balloon dilatation	30475
joint, removal of	(see arthrotomy)	Gastroduodenostomy	30515
maxillary sinus, removal of	41716	reconstruction of	30517
muscle/deep tissue, removal of	30067,30068	Gastroenterostomy	30515
nose, removal of	41659	Gastrointestinal blood loss estimation	12506
oesophagus, removal of	41825	protein loss	12509
subcutaneous, removal of	30064	tract, dilatation of stricture of upper	41819,41820
superficial, removal of	30061	Gastrostomy, operations for	43864,43867
tendon, removal of	30067,30068	Gastroscopy	30473,30476,30478
trachea, removal of	41886	insertion of nasogastric/nasoenteral tube	31456,31458
urethra, removal of	37318	Gastrostomy button, non-endoscopic insertion/replacement	30483
Fractures, treatment of	(see body part)	percutaneous endoscopic	30481,30482
Free grafts	45400-45494	percutaneous tube, jejunal extension	31460
split skin, to burns	45460-45494	with laparotomy	30375
transfer of tissue	45563-45565	Genioplasty	45761
transfer of tissue, anastomosis artery/vein	45502	Genital prolapse, operations for	35576,35580,35584
Frenulum, mandibular or maxillary, repair	30281	Gilliam's operation	35683,35684
Frontal sinus, catheterisation of	41740	Gland, adrenal, excision of	36500
sinus, intranasal operation on	41737	Bartholin's, marsupialisation of	35516,35517
sinus, radical obliteration of	41746	lacrimal, excision of palpebral lobe	42593
sinus, trephine of	41743	lymph, biopsy of	30074,30075
Fronto-ethmoidectomy, radical	41734	lymph, drill biopsy of	30078
Fronto-nasal ethmoidectomy	41731	lymph, pelvic, excision of	35551
Fronto-orbital advancement	45782,45785	lymph, pelvic, excision of, with hysterectomy	35664
Full thickness grafts, free	45451	parotid, superficial lobectomy/tumour removal	30253
thickness wedge excision of lip, eyelid or ear	45665	parotid, total extirpation of	30247,30250
Fundi, optic, examination of	11212	salivary, duct, dilatation or diathermy of	30262
Fundoplasty/fundoplication, antireflux operation	30527,30529,30530	salivary, duct, marsupialisation	30265,30266
antireflux operation by	31464,31466	salivary, duct, meatotomy	30265,30266
Funnel chest, elevation of	38457,38458	salivary, duct, removal of calculus	30265,30266
Furuncle, incision with drainage of	30219,30223	salivary, operations on	30262-30269
Fusion, spinal, cervical/thoracic/lumbar	48660-48675	sublingual, extirpation of	30259
spinal, posterior interbody	48654,48657	submandibular, extirpation of	30256
vertebral body, diseases of	48640	Glaucoma, filtering and allied operations for	42746,42749
G			
Gallbladder, drainage of	30375	Molteno valve, insertion of	42752
excision of	30443-30449	Molteno valve, removal of	42755
Galvanocautery of skin lesions	30192	iridectomy and sclerectomy for	42746
Gamete intra-fallopian transfer	13200-13221	iridectomy or iridotomy	42764
Ganglion, excision of	30106,30107	provocative tests for	11200
hand, excision of	46494,46495,46498	tonography for, one or both eyes	11203
wrist joint, excision of	46500-46503	Glenoid fossa, reconstruction of	45788
Gangliotomy, radiofrequency trigeminal	39109	Glioma, craniotomy for removal of	39709
		Globe of eye, visceration of	42512,42515
		Glomus tumour, transmastoid removal of	41623
		tumour, transtympanic, removal of	41620

* Payable on attendance basis

Service	Item	Service	Item
Glossectomy, with partial pharyngectomy	41785	- following tonsillectomy, with GA	41796,41797
Gonadal dysgenesis, vaginoplasty for	37851	extremity, reoperation for control of	33848
Goniotomy	42758	intracranial, burr-hole craniotomy for	39600
Graciloplasty procedures	32200,32210	nasal, arrest of	41656,41677
Grafenberg's (or Graf) ring, introduction of	35503	nasal, cryotherapy for treatment of	41680
ring, removal under GA	35506	post-op, control under GA, independent	30058
Graft, axillo-femoral, infected, excision of	34172	post-operative, following gynaecological surgery	35759
bone	(see bone)	post-operative, laparotomy for	30385
bypass, for occlusive arterial disease	32700,32763	postpartum, treatment of	16567
bypass, for treatment of aneurysm	(see aneurysm)	subdural, tap for	39009
composite (chondro-cutaneous/mucosal)	45656	Haemorrhoidectomy	32138,32139
conjunctival over cornea	42638	Haemorrhoids, injection into	*
corneal	42653,42656,42659	removal of	32138,32139
dermis, dermo-fat or fascia	45018	rubber band ligation of	32135
femoro-femoral, infected, excision of	34172	sclerotherapy for	32132
free fascia for facial nerve paralysis	45575,45578	Hair transplants, congenital/traumatic alopecia	45560
free, split skin	45400,45494	Hallux rigidus/valgus, correction of	49821,49842
inlay, using a mould	45445	Halo, application	47711,47714
micro-arterial or micro-venous	45503	femoral traction, application of	47720,47723
nerve	39315,39318	thoracic traction, application of	47717
skin, to orbit	42524	Hammer toe, correction of	49848
venous, to fenestration cavity		Hand, amputation or disarticulation of	44325,44328
Grafting, bypass, occlusive arterial disease	(see bypass)	arthrotomy	46327,46330
bypass, treatment of aneurysm	(see aneurysm)	bone grafting for pseudarthrosis	46405
for symblepharon	45629	congenital abnormalities, amputation of phalanges	50396
patch, to artery or vein	33545,33548	congenital abnormalities, splitting of phalanges	50396
Granuloma, cautery of	42677	decompression fasciotomy	47981
removal from eye, surgical excision	42689	digits, flexor/extensor contracture, correction	46492
umbilical, excision under GA	43948	duplication of digits, amputation of phalanges	50396
Gravid uterus, evacuation of contents by curettage	35643	duplication of digits, splitting of phalanges	50396
Great vessel, intrathoracic operation on, other	38456	extensor tendon of, repair of	46420,46423
vessel, ligation or exploration, other	34103	extensor tendon of, tenolysis of	46450
Greater trochanter, transplant of ileopsoas tendon	50121	flexor tendon of, repair of	46423,46435
Groin, lymph, excision of	30329,30330	flexor tendon of, tenolysis of	46453
Grommet, free, in canal, removal of	*	ganglion, excision of	46494
in situ in drum, removal of	41500	middle palmar/thenar/hypothenar spaces, drainage	46519
insertion of	41632	osteectomy/osteotomy	46396,46399
Group psychotherapy	342	paronychia/pulp space infection, incision for	46525
psychotherapy, family	342,344,346	tendon sheath, operation for tendovaginitis	46363
therapy, family	170,171,172	tendon transfer for restoration of function	46417
Gunderson flap operation	42638	Hare lip	(see left lip)
Gynaecological examination under GA	35500	Harrington rods, in treatment of scoliosis or kyphosis	48609
Gynatresia, vaginal reconstruction for	35565	rods, re-exploration for adjustment /removal	48615
		Hartmann's operation	32030
		Health assessments	700-706
		Care planning	720-730
		Case conferencing (other than Specialist or Cons Physician)	734-7
		Case conferencing by Consultant Physician	801-815
		Heart arrhythmia, ablation of	38287,38290,38293
		arrhythmia, surgery for	38512-38536
		catheterisation of	38200,38203,38206
		electrical stimulation of	13400
		intrathoracic operation on, not otherwise covered	38456
		mitral annulus, reconstruction after decalcification	38485
		subvalvular structures, reconstruction, re-implantation	38490
		surgery for congenital heart disease	38700,38766
		surgery, open, not otherwise covered	38653
		valve replacement	38488,38489
		valve, repair	38480,38481
		Heller's operation	30532,30533
		Hemiarthroplasty, hand	46309,46321
		knee	49517
		Hemicircumcision, for hypospadias	37354
		Hemicolectomy	32000,32003,32006

* Payable on attendance basis

Service	Item	Service	Item
Hemiepiphysis, staple arrest of	48509	Hydrocephalus, operations for	40000-40009
Hemifacial microsomia, construction condyle and ramus	45791	Hydrocortisone, injections into keloid with GA	30210
Hemilaryngectomy, vertical, with tracheostomy	41837	Hydrodilatation of bladder with cystoscopy	36827
Hemispherectomy, for intractible epilepsy	40706	Hydromyelia, operations for	40339,40342
Hemithyroidectomy	30306	Hydrotubation of Fallopian tubes	35703,35709
Hemivulvectomy	35536	Hymenectomy	35509
Hepatic duct, common, resection for carcinoma	30463,30464	Hyperbaric oxygen therapy	13020,13025,13030
duct, common, repair of	30472	Hyperemesis gravidarum, treatment of	16505
ducts, Roux-en-Y bypass	30466,30467	Hyperextension deformity of toe, release, lengthening	50345
Hernia, antireflux operations for	30527,30529,30530	Hyperhidrosis, axillary, excision for	30180,30183
diaphragmatic, neonatal, repair of	43837,43840	Hyperparathyroidism, operations for	30315-30320
diaphragmatic, repair of	30600,30601	Hypertelorism, correction, intra/sub-cranial	45767,45770
diaphragmatic, simple closure of	30387	Hypertension, portal, treatment of	30602-30606
femoral or inguinal, repair of	30609,30612,30614	Hyperthermia treatment using Tronado unit	*
inguinal, repair, age less than 3 months	44108,44111,44114	Hypnotherapy	*
spigelian, repair of	30403,30405	Hypodermic injections	*
strangulated, incarcerated or obstructed, repair of	30615	Hypospadias, examination under GA	37815
umbilical, epigastric, or linea alba, repair of	30616-30621	granuloplasty, meatal advancement	37818
ventral or incisional, repair of	30403,30405	meatotomy and hemi-circumcision	37354
ventral, following closure exomphalos, repair of	43939	penis erection test with examination	37815
Herniated muscle, fascia, deep, repair of	30238	repair of	37821-37833
Hiatus hernia, antireflux operations for	30527,30529,30530	urethral fistula repair	37833
hernia, repair of	30601	Hypothenar spaces of hand, drainage of	46519
para-oesophageal, repair of	31468	Hypothermia, gastric	13500,13503
Hickman catheter, insertion of, for chemotherapy	34527,34528	deep hypothermic circulatory arrest	22075
catheter, removal of	34530	total body	22065
Hindquarter, amputation or disarticulation of	44373	Hysterectomy	35653-35673
Hinselmann colposcope, examination uterine cervix	35614	laparoscopically assisted	35750-35756
Hip, amputation or disarticulation at	44370	with ovarian transposition, malignancy	35729
arthrectomy	49309,49312	Hysteroscopic resection of myoma or uterine septum	35623,35634
arthrodesis	49306	resection of uterine septum	35634
arthroplasty	49309-49346	Hysteroscopy	35626- 35636
arthroplasty, revision	49346	Hysterotomy	35649
arthroscopy	49360,49363,49366		
arthrotomy	49303	I	
congenital dislocation, open reduction	50351	Ileal atresia, neonatal, laparotomy for	43816
contracture of, medial/anterior release	50375-50384	Ileo-femoral by-pass grafting	32712,32718
dislocation, acetabulum fracture, treatment	47495,47498	endarterectomy	33521
dislocation, congenital, treatment of	50349,50352,50350	Ileorectal anastomosis	32012
dislocation, treatment of	47048,47051	Ileostomy	32009-32021
iliopsoas tendon transfer to greater trochanter	50387	closure of, with rectal resection	32060,32063,32066
prosthesis, operation on	49315	closure of, without resection of bowel	30562
replacement procedures	49318-49345	refashioning of	30563
spica, application of	47540	reservoir, continent type, creation of	32069
spica, initial application, congenital dislocation	50353	trimming	*
transfer of abdominal musculature to greater trochanter	50387	with proctocolectomy	32015
transfer of adductors to ischium	50387	with total colectomy	32009
Hirschsprung's disease, colostomy/enterostomy for	30375	Iliac endarterectomy	33518
disease, neonatal, laparotomy for	43819	vein, thrombectomy	33810,33811
disease, paediatric, operations for	43990-43999	vessel, ligation or exploration not otherwise covered	34103
Hormone implantation, by cannula	14206	Iliopsoas tendon transfer to greater trochanter	50387
implantation, direct, incision and suture	14203	Immunisation against infectious disease	*
Humerus, bone graft to	48212,48215	Implant, cochlear, insertion of	41617
fracture, treatment of	47411-47459	epidural, for pain management, removal of	39136
operation for osteomyelitis	43506,43515	foreign, insertion for contour reconstruction	45051
osteectomy/osteotomy	48412,48415	insertion or removal from eye socket	42518
Hummelsheim type muscle transplant, squint	42848	Implantation, fallopian tubes into uterus	35694,35697
Hydatid cyst, liver, total excision of	30437,30438	hormone or living tissue	14203,14206
cyst, liver, removal of contents of	30434,30436	Implanted, pacemaker testing	11718,11721
cyst, lungs, enucleation of	38424	device for delivery of therapeutic agents	14221
Hydradenitis, excision for	31245	pump or reservoir, loading of	14218
Hydrocele, infantile, repair of	30612,30614	reservoir associated with adjustable gastric band	14215
removal of	30631	Impotence, injection for investigation/treatment	37415
tapping of	30628		

* Payable on attendance basis

Service	Item	Service	Item
Incidental appendectomy	30574	Interventional endovascular procedures	35300-35330
Incisional hernia, repair of	30403	Intervertebral disc/s, laminectomy for removal of disc/s, microsurgical discectomy of	40300 40301
Incomplete confinement	16518	Intestinal conduit or reservoir, endoscopic examination	36860
Incontinence, anal, Parks' intersphincteric procedure	32126	duct, patent vitello, excision of	43945
bladder stress, suprapubic operation	37044	malrotation, neonatal, laparotomy for	43801,43804
male urinary, injection for treatment of	37339	obstruction, surgical relief of	30387
stress, sling operation for	35599	plication, Noble type, with enterolysis	30375
Indirect flap	45227-45239	remnant, abdominal wall vitello, excision of	43942
Induction, management, second trimester labour	16525	resection, large	32000,32003
Indwelling oesophageal tube, gastrostomy for fixation	30375	resection, small	30565,30566
Infantile hydrocele, repair of	30612,30614	sling procedure prior to radiotherapy	32183
Infection, acute intercurrent, complicating pregnancy	16508	urinary conduit, revision	36609
Inferior vena cava, thrombectomy	33810,33811	urinary reservoir, continent, formation	36606
vena caval filter, insertion of	35330	Intra-abdominal artery/vein, cannulation, chemotherapy	34521
Infiltration, alcohol, etc, around nerve or in muscle of local anaesthetic	*	malignancy, radical or debulking operation	30392
(see explain notes)		Intra-anal abscess, drainage of	32174,32175
Inflammation of middle ear, operation for	41626	Intra-aortic balloon, counterpulsation, management	13845,13848
Infusion chemotherapy	13915-13936	balloon pump, insertion of	38606,38609
chemotherapy, cannulation for	34521,34524	balloon pump, removal of	38612,38613
device, automated, spinal, insertion of	39126,39128	Intra-arterial cannulisation for blood collection	13842
intra-arterial, sympatholytic agent	14209	infusion chemotherapy	13927-13936
Ingrowing eyelashes, operation for	45626	infusion, of sympatholytic agent	14209
nail of finger or thumb, resection of	46528,46531	Intra-atrial baffle, insertion of	38745
nail of toe, resection of	47915,47916	Intra-epithelial neoplasia, laser therapy for	35539,35542,35545
Inguinal abscess, incision of	30223	Intra-ocular excision of dermoid of eye	42574
hernia, repair of	30609,30612,30614	foreign body, removal of	42560-42569
hernia, repair, age less than 3 months	44108,44111,44114	procedures, resuturing of wound after	42857
Injection, alcohol, etc, around nerve or in muscle	*	Intra-operative ultrasound, biliary tract	30439
alcohol, cortisone, phenol into trigeminal nerve	39100	staging of intra-abdominal tumours	30441
alcohol, retrobulbar	42824	Intra-oral tumour, radical excision of	30275
botulinus toxin	42827	Intra-orbital abscess, drainage of	42572
hormones, for habitual miscarriage	16504	Intra-uterine contraceptive device, introduction of	35503
immunoglobulin	*	contraceptive device, removal of under GA	35506
into angioma (restriction applies)	45027	growth retardation, attendance for	16508
into joint/synovial cavity	50124,50125	Intracerebral tumour, craniotomy and removal of	39709
into prostate	37218	Intracranial abscess, excision of	39903
into spinal joints or nerves	39013	aneurysm, clipping or reinforcement of sac	39800
intramuscular	*	aneurysm, ligation of cervical vessel/s	39812
intravenous	*	arteriovenous malformation, excision of	39803
local anaesthetic	(see explain notes)	cyst, drainage of via burr-hole	39703
sclerosant fluid into pilonidal sinus	30679	electrode placement	40709,40712
Injections, multiple, for skin lesions	30207	haemorrhage, burr-hole craniotomy for	39600,39603
varicose veins	*	infection, drainage of via burr-hole	39900
Inlay graft, using a mould	45445	neurectomy, for trigeminal neuralgia	39106
Innocent bone tumour, excision of	30241	pressure monitoring device, insertion of	39015
Innominate artery, endarterectomy of	33506	pressure monitoring, catheter/subarachnoid bolt	13830
Inoculation against infectious disease	*	stereotactic procedures	40800,40803
Insufflation Fallopian tubes, for patency (Rubin test)	35706	tumour, biopsy and/or decompression	39706
Intensive care management/procedures	13815-13888	tumour, burr-hole biopsy for	39703,39706
Intercostal drain, insertion of	38409,38410	tumour, craniotomy and removal of	39709,39712
Internal auditory meatus, exploration of	41599	Intradiscal injection of chymopapain	40336
drainage of empyema, without rib resection	38409,38410	Intradural lesion, laminectomy for, not otherwise covered	40312
Interosseous muscle space of hand, fasciotomy of	47981	Intrahepatic bypass	30466,30467
Interphalangeal joint, arthrodesis of	46300	Intramedullary tumour, laminectomy and radical excision	40318
joint, arthrotomy of	46327,46330	Intramuscular injections	*
joint, dislocation, treatment of	47036,47039	Intranasal operation on antrum/removal of foreign body	41716
joint, hemiarthroplasty	46309-46321	operation on frontal sinus or ethmoid sinuses	41737
joint, interposition arthroplasty of	46306	operation on sphenoidal sinus	41752
joint, joint capsule release of	46381	Intrascleral ball or cartilage, insertion of	42515
joint, ligamentous repair	46333	Intrathecal infusion device, revision of	39133
joint, synovectomy/capsulectomy/debridement	46336	infusion/injection	(see Group T7)
joint, total replacement arthroplasty of	46309-46321	steroid injection	18232
joint, volar plate arthroplasty	46307	Intrathoracic operation on heart, lungs, etc, other	38456
Interscapulothoracic amputation or disarticulation	44334		

* Payable on attendance basis

Service	Item	Service	Item
vessels, anastomosis/repair	38727,38730		
Intravascular injections	*	K	
pressure monitoring	13876		
Intravenous infusion chemotherapy	13915-13924	Keloid, excision of	(see tumour,other)
injections	*	extensive, multiple injections of hydrocortisone	30210
perfusion of a sympatholytic agent	14209	Keratotomy, partial, for corneal scars	42647
regional anaesthesia of limb	18213	phototherapeutic	42810
Intraventricular baffle, insertion of	38754	Keratocanthoma, removal of	31255-31295
Intubation, small bowel	30487,30488	Keratoplasty	42653,42656,42659
Intussusception, laparotomy and reduction of	30375	refractive	42671
management fluid/gas reduction for	14212	Keratosis, obturans, surgical removal	41509
paediatric, operations for	43933,43936	treatment of	*
Invitro fertilisation	13200-13221	Kidney, dialysis, in hospital	13100,13103
processing of bone marrow	13760	donor, continuous perfusion of	22055
Ionisation, cervix	35608	exploration of	36537
corneal ulcer	*	ruptured, exposure and exploration of	36576
zinc, of nostrils, in the treatment of hay fever	*	solitary, pyeloplasty by open exposure	36567
Iontophoresis, collection of specimen of sweat by	12200	transplant	36503,36506,36509
Iridectomy	42764	Kirschner wire, insertion of	47921
and sclerectomy, for glaucoma (Lagrange's op)	42746	Klockoff's test, assessment of cochlear function changes	11321
following intraocular procedures	42857	Knee, amputation at or below	44367
Iridencleisis	42746	arthrodesis of	49512,49545
Iridocyclectomy	42767	arthroplasty of	49518-49534
Iridotomy	42764	arthroscopy of	49557-49566
laser	42785,42786	arthrotomy of	49500
Iris and ciliary body, excision of tumour of	42767	collateral or cruciate ligament repair	49503,49506
excision of tumour of	42764	congenital deformity, post-op manipulation, plaster	50348
tumour, laser photocoagulation of	42806	contracture of, posterior release	50363-50372
Iron kinetic test	12503	cruciate ligament reconstruction	49536,49539,49542
Ischaemic limb, debridement of deep tissue	35100	dislocation, treatment of	47054
limb, debridement of superficial tissue	35103	fracture, treatment of	47588,47591
ventricular septal rupture, repair of	38509	hamstring tendon transfer	50357,50360
Ischio-rectal abscess, drainage of	32174,32175	hemiarthroplasty of	49517
abscess, incision with drainage	30223	ligament or tendon transfer	49503,49506
		meniscectomy of	49503,49506
		mobilisation, for post-traumatic stiffness	49569
		nerve block for control of post op pain	18210,18211
		orthopaedic treatment of	49503,49506
		patello-femoral stabilisation	49503,49506,49564
		patello-femoral stabilisation, revision of	49548
		prosthesis, removal of	49515
		reconstruction/repair	49536,49539
		rectus femoris tendon transfer	50357
		replacement procedures	49518-49534
		revision of orthopaedic procedures	49551,49554
		synovectomy of	49509
		Kyphosis, spinal fusion for	48606,48609,48613
			L
		Labial adhesions, separation of	*
		Labioplasty, where medically indicated	35533
		Labour, second trimester, management of	16525
		Labyrinth, destruction of	41572
		Labyrinthotomy	41572
		Labyrinths, caloric test of	11333,11336
		Laceration, ear/eyelid/nose/lip, full thickness, repair	30052
		repair and suturing of	30026-30049
		Lacrimal canalicular system, establishment patency	42599,42602
		canaliculus, immediate repair of	42605
		drainage by insertion of glass tube	42608
		gland, excision of palpebral lobe	42593
		passages, obstruction, probing for	42610-42615
		sac, excision of	42596

* Payable on attendance basis

Service	Item	Service	Item
Lagrange's operation (iridectomy and sclerectomy)	42746	destruction of stone with urethroscopy	37318
Laminectomy and insertion of epidural implant	39139	division of suture, eye	42794
followed by posterior fusion	40324,40327	excision, tumours of face/neck	30190
for cordotomy or myelotomy	39124	excision/ablation, carbon dioxide or erbium, of rhinophyma	45652
for extradural tumour or abscess	40309	excision/ablation, carbon dioxide or erbium, vermilionectomy	456
for hydromelia	40342	incision of palate	41787
for intradural lesion	40312	iridotomy	42785,42786
for recurrent disc lesion and/or spinal stenosis	40303	photocoagulation of iris tumour	42806
for removal of intervertebral disc/s	40300	photocoagulation of neoplastic skin lesions	30195
for spinal stenosis	40303,40306	photocoagulation of vascular lesions	14100-14132
with bone graft and posterior fusion	48654,48657	photoiridosyneresis	42808
with excision of arteriovenous malformation	40318	photomydriasis	42807
with excision of intra-medullary tumour	40318	removal of cancer of skin/mucous membrane	30196
Laparoscopic division of adhesions	31450,31452,35637	removal of palmar/plantar warts	30187
splenectomy	31470	resurfacing, carbon dioxide, face or neck	45025,45026
Laparoscopy and hysteroscopy under GA	35636	therapy for intraepithelial neoplasia	35539,35542,35545
complicated operative	35638,35641	therapy for malignancy of gastrointestinal tract	30479
diagnostic	30390	trabeculoplasty	42782,42783
division of adhesions	30393,35637	treatment, eye	42782-42806
involving procedures via laparoscope	35637,35638	vitrealysis/corticolysis	42791,42792
laparoscopically assisted hysterectomy	35750-35756	Lateral pharyngeal bands, removal of	41804
sterilisation via	35687,35688	pharyngotomy	41779
with biopsy	30391	rhinotomy with removal of tumour	41728
with drainage of pus	31454	Lavage and proof puncture of maxillary antrum	41698,41701
with transection/resection Fallopian tubes	35687,35688	colonic, total, intra-operative	32186
Laparostomy	30397,30399	colostomy	*
Laparotomy and division of adhesions	30376,30378,30379	gastric, in the treatment of ingested poison	14200
exploratory	30373	maxillary antrum	41704
for control of post-operative haemorrhage	30385,33845	stomach	*
for drainage	30394	uterine (saline flushing)	*
for grading of lymphoma	30384	Le Fort osteotomies	45753,45754
for gross intra-peritoneal sepsis	30396	operation for genital prolapse	35584
for intussusception, paediatric	43933,43936	Leg, amputation	44367,44370
for neonatal conditions	43801-43831	hamstring tendon transfer	50357,50360
for staging of gynaecological malignancy	35726	rectus femoris tendon transfer	50357
for thrombosis	33845	Lens, artificial, insertion of	42701,42703
for trauma, involving 3 or more organs	30388	artificial, removal and replacement	42707,42710
involving gynaecology (exc. hysterectomy)	35712-35717	artificial, removal or repositioning	42704
involving other op on abdominal viscera	30375,30387	extraction	42698
with division of extensive adhesions	30379	extraction and insertion of artificial lens	42702
with insertion of portacath	30400	intraocular, repositioning of	42713
Large intestine, resection of	32000,32003	Lensectomy	42731
intestine, subtotal colectomy	32004,32005	Lesion, craniocervical junction, transoral approach for	40315
Laryngeal web, division of	41868	intradural, laminectomy for, not otherwise covered	40312
Laryngectomy	41834	Lesions, skin, multiple injections for	30207
supraglottic	41840	Leukoplakia, tongue, diathermy for	*
Laryngofissure, external operation on	41876	Leveen shunt, insertion of	30408
Laryngopharyngectomy	41843	Lid, ophthalmic, suturing of	42584
- or primary restoration of alimentary continuity after	41843	scleral graft to	42860
- with tracheostomy and plastic reconstruction	30294	Ligament, finger joint, repair of	46333
Laryngoplasty	41876,41879	of foot, repair of	49812
Laryngoscopy	41846,41849,41852	or tendon transfer	47966
fibreoptic, with examination of larynx	41764	ruptured medial palpebral, repair of	42854
Larynx, direct examination of	41846	transplantation	47966
direct examination of, with biopsy	41849	Ligation, great vessel	34103
direct examination of, with removal of tumour	41852	purse string, cervix	16511
external operation on	41876	rubber band, of haemorrhoids or rectal prolapse	32135
fibreoptic examination of	41764	transantral, of maxillary artery	41707
fractured, operation for	41873	Ligature of cervix, purse string, removal of	16512
Laser ablation of prostate, endoscopic	37207,37208	Limb, fasciotomy of	30226
angioplasty, peripheral	35315	Limb, amputation	(see leg/arm)
capsulotomy	42788,42789	ischaemic, debridement of tissue	35100,35103
coagulation corneal/scleral vessels	42797	lengthening procedures	50303,50306
destruction of bladder tumour with cystoscopy	36839,36845	lower, congenital deficiency, treatment of	50411,50414,50417

* Payable on attendance basis

Service	Item	Service	Item
or chest, decompression escharotomy	45054	Lymph glands, axilla, excision of	30332,30336,30335
perfusion of	22055,34533	glands, biopsy of	30074,30075,30078
Limbic tumour, removal or excision of	42692,42695	glands, groin, excision of	30329,30330
Linea alba hernia, repair of, under 10 years	30616,30617	glands, pelvic, radical excision of	35551
alba hernia, repair of, over 10 years	30620,30621	node biopsies, retroperitoneal	35723
Lingual tonsil, removal of	41804	node dissection, retroperitoneal	37607,37610
Lip, cleft, operations for	45677-45704	node of neck, biopsy of	31420
full thickness laceration, repair	30052	nodes of axilla, excision of	30335,30336
full thickness wedge excision	45665	nodes of neck, dissection of	31423-31438
reconstruction	45671,45674	Lymphadenectomy, atypical mycobacterial infection	44130
tumour, excision of (see tumour , other)	30177	granulomatous disease	44130
Lipectomy, radical abdominoplasty	30174	pelvic	35551,36502
subumbilical excision	30174	Lymphangiectasis, limbs, major excision	45048
wedge excision	30165,30168,30171	Lymphangioma, excision of	45030-45036
Lipoma, removal of (see tumour , other)	40112	Lymphoedema, major excision of	45048
Lipomeningocele, tethered cord, release of	40112		
Liposuction, treatment of post-traumatic pseudolipoma	45584,45585		
Lippe's loop, introduction of	35503	M	
loop, removal of under GA	35506	Macrocheilia, operation for	45675
Lisfranc's amputation	44364	Macroductyly, surgical reduction of enlarged elements	46510
Litholapaxy, with or without cystoscopy	36863	Macroglossia, operation for	45675
Lithotripsy, extracorporeal shock wave (ESWL)	36546	Macrostomia, operation for	45676
Little's Area, cautery of	41674	Macules, electrosurgical destruction or chemotherapy of	*
Liver abscess, open abdominal drainage of	30431,30433	Magnetic removal of intraocular foreign body	42560,42566
biopsy	30409,30411,30412	Malignant lesion, removal of	31300-31335
cyst/s, laparoscopic marsupialisation	30416,30417	Malignant upper aerodigestive tract tumour	31400,31403,31406
hydatid cyst, removal of contents of	30434,30436	excision of	
hydatid cyst, total excision of	30437,30438	Mallet finger, closed pin fixation of	46438
lobectomy of, for trauma	30428,30430	finger, open repair of text test	46441
lobectomy of, other than for trauma	30418,30421	finger, with intra-articular fracture, open reduction	46442
repair of laceration/s, for trauma	30422,30425	Mammoplasty, augmentation	45524,45527,45528
ruptured, repair	30375	reduction	45520,45522
segmental resection of	30414,30415,30427	Mammary prosthesis, removal of	45548,45551,45552
tumours, destruction of by cryotherapy	30419	prosthesis, replacement of	45552,45554
Living tissue, implantation of	14203,14206	Manchester operation for genital prolapse	35584
Lobar emphysema, neonatal, thoracotomy & lung resection	43861	Mandible, condylectomy	45611
Lobectomy, liver, for trauma	30428,30430	dislocations, treatment of	47000
liver, other than for trauma	30418,30421	hemi-mandibular reconstruction with bone graft	45608
lung	38438,38441	operation on, for acute osteomyelitis	43503
partial, for epilepsy	40703	operation on, for chronic osteomyelitis	43512
superficial, of parotid gland	30253	or maxilla, fractures, treatment of	47753-47789
Local anaesthetic, injection of (see explain notes)	45200,45203,45206	osteotomy or osteotomy of	45720-45752
flap repair	45239	resection of	45599,45602,45605
flap revision	*	segmental resection of, for tumours	45605
infiltration, nerve/muscle, with alcohol etc.	(see arthrotomy)	Mandibular, frenulum, repair of, under GA	30281
Loose bodies in joint	45659	Manipulation of fibrous tissue surrounding breast prosthesis	*
Lop ear or similar deformity, correction of	32153	of joints	50115
Lord's procedure, massive dilatation of anus	40018	of spine	48600,48603
Lumbar cerebrospinal fluid drain, insertion of	40351	of ureteric calculus, endoscopic	36857
decompression of spinal cord	48636	without anaesthesia	*
discectomy, percutaneous	39000	Manometric oesophageal motility test	11800
puncture	40006	Manometry, biliary	30493
shunt diversion, insertion of	40009	Marshall-Marchetti operation for urethropexy	35599,37044
shunt, revision or removal of	35000,35009	Marsupialisation of Bartholin's cyst or gland	35516,35517
sympathectomy	48406	salivary gland	30265,30266
Lunate bone, osteectomy or osteotomy of	11503	Mastectomy, total	31521,31518
Lung compliance, estimation of	38424	subcutaneous	31524,31527
hydatid cysts, enucleation of	38456	Mastitis, granulomatous, exploration and drainage	31551
intrathoracic operation, not otherwise covered	38412	Mastoid cavity, obliteration of	41548,41564
needle biopsy of	43861	portion, decompression of facial nerve	41569
resection, congenital cystadenomatoid malformation	43861	Mastoidectomy, cortical	41545
resection, congenital lobar emphysema	11503	intact wall technique, with myringoplasty	41551,41554
volumes	38440	radical or modified radical	41557-41564
wedge resection of		revision of, with myringoplasty	41566

* Payable on attendance basis

Service	Item	Service	Item
with insertion of cochlear implant	41617	Micro-arterial graft	45503
with transmastoid removal of glomus tumour	41623	Microdochotomy of breast, benign or malignant condition	31554
Maxilla, operation on, for acute osteomyelitis	43503	Micro-laryngoscopy	41855
operation on, for chronic osteomyelitis	43512	- with arytenoidectomy	41867
or mandible, fractures, treatment of	47753-47789	- with division of laryngeal web	41868
osteectomy or osteotomy	45720-45752	- with removal of juvenile papillomata	41858
resection of, segmental, for tumour/cyst	45605	- with removal of papillomata by laser surgery	41861
resection of, sub-total	45602	- with removal of tumour	41864
resection of, total	45596,45597	Microsomia, construction of condyle and ramus	45791
Maxillary antrum, lavage of	41704	Microvascular anastomosis using microsurgical techniques	45502
antrum, proof puncture and lavage of	41698,41701	repair using microsurgical techniques	45500,45501,45504
artery, transantral ligation of	41707	Microvenous graft	45503
frenulum, repair of	30281	Middle ear, clearance of	41635,41638
sinus, drainage of, through tooth socket	41719	ear, exploration of	41629
sinus, operations on	41710-41722	ear, insertion of tube for drainage of	41632
Meatoplasty, with correction of auditory canal stenosis	41521	ear, operation for abscess or inflammation of	41626
with removal of cartilage and/or bone	41512,41515	palmar spaces of hand, drainage of	46519
Meatotomy and hemi-circumcision, hypospadias	37354	Midtarsal amputation of foot	44364
ureteric, with cystoscopy	30265,30266,36830	Miles' operation	32039
urethral	37321	Minitracheostomy insertion	41884
Meatus, external auditory, removal of exostoses in	41518	Minnesota tube, insertion of	13506
external auditory, removal of keratosis obturans	41509	Miscarriage, habitual, treatment of	16504
internal auditory, exploration of	41599	incomplete, curettage for	35639,35640
pinhole urinary, dilatation of	37300	threatened, ligation of cervix	16511
Meckel's diverticulum, removal of	30375	threatened, treatment of	16505
Meconium ileus, laparotomy for	43813,43816	Mitral annulus, reconstruction after decalcification	38485
Medial palpebral ligament, ruptured, repair of	42854	valve, open valvotomy of	38487
Median bar, endoscopic resection of	36854	Mitrofanoff continent valve, formation of	37045
sternotomy for post-operative bleeding	38656	Moh's procedure	31000,31001,31002
Mediastinum, cervical exploration of	38448	Mole, desiccation by diathermy	*
exploration of, for hyperparathyroidism	30318,30320	retained, evacuation of	16564
intrathoracic operation on, not otherwise covered	38456	Molluscum contagiosum, removal in operating theatre	30189
Meibomian cyst, extirpation of	42575	Morbid obesity, operations for	30511,30512,30514
Melanoma, removal of	31300-31335	Moschowitz operation	35590
Melasma, full face chemical peel	45019,45020	Motility test, manometric, of oesophagus	11800
Meloplasty, for correction of facial asymmetry	45587,45588	Mouth, premalignant growth in, removal of (see tumour,other)	
Membranes, retained, evacuation of	16564	Mucous membrane, biopsy of	30071
Meningeal haemorrhage, operations for	39600,39603	membrane, cancer, treatment	30196-30205
Meningocele, excision and closure of	40100	membrane, graft	42641
Meniscectomy, knee	49503,49506	membrane, repair of recent wound	30026-30049
temporo-mandibular	45755	Multiple delivery, administration of anaesthetic	
Mesenteric artery, inferior, operation on	32736	Multiple, injections for varicose veins	32500,32501
vessels, by-pass grafting to	32730,32733	pregnancy, interventional techniques	16633,16636
Meso caval shunt for portal hypertension	30603	Muscle, activity sampling (electromyography)	11012,11015,11018
Metacarpal bones, amputation of	44325	biopsy of	30074,30075
bones, bone grafting, pseudarthrosis	46402,46405	distal, devascularisation of	32200
bones, fracture, treatment of	47336-47345	excision of	30226,30229
bones, operation for osteomyelitis	46462	excision of, with melanoma	31340
bones, osteotomy/osteectomy	46396,46399	extra-ocular, ruptured, repair of	42854
Metacarpophalangeal joint, arthrodesis	46300	flap repair	45000,45009,45012
joint, arthroplasty	46306-46321	flap, delay of	45015
joint, arthrotomy	46327,46330	local infiltration in	*
joint, dislocation, treatment of	47042,47045	removal of foreign body from	30067,30068
joint, hemiarthroplasty	46309-46321	ruptured, repair of	30232,30235
joint, ligamentous repair of	46333	transfer for facial nerve paralysis	45578
joint, volar plate arthroplasty	46307	transplant (Hummelsheim type), for squint	42848
Metacarpus, operation on, for chronic osteomyelitis	43512	Myelomeningocele, excision and closure of	40103
Metastatic carcinoma, craniotomy for removal of	39709	Myelotomy, laminectomy for	39124
Metatarsal bones, osteotomy or osteectomy of	48400,48403	Myocardial electrode, permanent, insertion, thoracotomy	38470
fracture, treatment of	47633-47657	biopsy, by cardiac catheterisation	38275
Metatarso-phalangeal joint, synovectomy of	49860,49863	Myocutaneous flap, delay of	45015
joint, total replacement of	49857	flap repair	45003,45006
Metatarsus, amputation or disarticulation of	44358	Myoma, hysteroscopic resection	35623
operation on, for acute osteomyelitis	43500	Myomectomy, hypertrophic obstructive cardiomyopathy	38650

* Payable on attendance basis

Service	Item	Service	Item
uterine, abdominal	35649	drainage tube, exchange of, imaging guided	36649
uterine, laparoscopic	35638	percutaneous, using interventional imaging	36624
Myotomy, cricopharyngeal	41770,41776	Nerve Block	(see Nerve)
hypertrophic obstructive cardiomyopathy	38650	separate examination in preparation for	17603
ocular muscles	42833,42839,42851	Nerve block, regional or field	18206,18298
oesophagogastric (Heller's operation)	30532,30533	conduction studies	11012,11015,11018
Myringoplasty	41527,41530	cranial, intracranial decompression	39112
- and mastoidectomy	41551,41560	cutaneous, nerve graft to	39318
- and ossicular chain reconstruction	41542	cutaneous, repair of	39300,39303
- and revision of mastoidectomy	41566	exploration of	39330
- with mastoidectomy and ossicular chain recon	41554,41563	facio-hypoglossal or facio-accessory, anastomosis of	39503
Myringotomy	41626	graft to nerve trunk	39315
		intracranial, for trigeminal neuralgia	39106
		local infiltration around, with alcohol etc	*
		peripheral, removal of tumour from	39324,39327
		section, retrolabyrinthine, vestibular/cochlear	41596
		section, translabyrinthine, vestibular	41593
		transposition of	39321
		trigeminal, primary branch, injection with alcohol etc	39100
		trunk, internal (interfascicular), neurolysis of	39312
		trunk, microsurgical repair	39306,39309
		trunk, nerve graft to	39315
		vestibular, section of, via posterior fossa	39500
		Neurectomy, foot, for plantar digital neuritis	49866
		intracranial, for trigeminal neuralgia	39106
		peripheral nerve	39324,39327
		transantral vidian, with antrostomy	41713
		Neuroblastoma, operations for	43981,43987,43984
		Neuroendocrine tumour, retroperitoneal, removal of	30321,30323
		Neuroendoscopy	40903
		Neurolysis, by open operation	39330
		of nerve trunk	39312
		Neuroma, acoustic, removal of	41575,41579
		Neuromuscular electrodiagnosis	11012-11021
		Neurostimulator receiver, spinal, subcutaneous placement	39134
		Neurotomy, of peripheral nerves	39327
		percutaneous, for facet joint denervation	39118
		percutaneous, of spinal nerves	39115
		Neurovascular island flap, for pulp innervation	46504
		island flap, with vascular pedicle	45563
		Nipple, accessory, excision of	31566
		inverted, surgical eversion of	31563
		reconstruction of	45545,45546
		Noble type intestinal plication with enterolysis	30375
		Node, lymph, biopsy of	30074,30075
		scalene, biopsy	30096
		Nodes, lymph, pelvic, excision of	35551
		Nodule, treatment, electro-surgical destruction/cryosurgery	*
		Non-gravid uterus, suction curettage of	35639,35640
		Nose, cauterisation or packing, for haemorrhage	41677
		composite graft to	45656
		cryotherapy to, for haemorrhage	41680
		dermoid of, congenital, excision of	41729
		foreign body in, removal of, other than simple	41659
		fracture, treatment of	47735,47738,47741
		full thickness repair of laceration (restriction)	30052
		operations, other	41659-41695
		plastic operations	45632-45653
			O
		Obesity, morbid, surgical reversal of gastric procedure	30514
		Ocular muscle, torn, repair of	42854
		surface dysplasia, investigation	11235

* Payable on attendance basis

Service	Item	Service	Item
Oculoplethysmography, carotid vessels	<u>11618,11621,11624</u>	Osteotomy of accessory bone	<u>48400</u>
Odontoid screw fixation	<u>40316</u>	carpus	<u>48406,48409</u>
Oesophageal atresia, neonatal, operations for	<u>43843-43858</u>	clavicle	<u>48406,48409</u>
atresia/corrosive stricture, replacement for	<u>43903</u>	femur	<u>48424,48427</u>
motility test, manometric	<u>11800</u>	fibula	<u>48406,48409</u>
perforation, repair of, by thoracotomy	<u>30560</u>	humerus	<u>48412,48415</u>
prosthesis, insertion of	<u>30490</u>	mandible or maxilla	<u>45720-45752</u>
stricture, endoscopic dilatation of	<u>41819,41820</u>	metatarsal	<u>48400,48403</u>
transection for portal hypertension	<u>30606</u>	pelvic bone	<u>48424</u>
tube, indwelling, gastrostomy for fixation	<u>30375</u>	pelvis	<u>48427</u>
Oesophagectomy	<u>30535-30557</u>	phalanx	<u>48400,48403</u>
cervical	<u>30294</u>	radius	<u>48406</u>
Oesophagogastric myotomy	<u>30532,30533</u>	rib	<u>48406</u>
Oesophagoscopy	<u>30473-30478</u>	scapula (other than acromion)	<u>48406</u>
with dilatation of stricture	<u>41819,41820</u>	sesamoid bone	<u>48400</u>
with rigid oesophagoscope	<u>41816,41822,41825</u>	tarsus	<u>48406</u>
Oesophagostomy, cervical	<u>30293,30294</u>	tibia	<u>48418,48421</u>
cervical, neonatal oesophageal atresia	<u>43858</u>	ulna	<u>48406</u>
closure or plastic repair of	<u>30293</u>	Osteomyelitis, acute or chronic, operations for	<u>43500-43524</u>
Oesophagus, resection of stricture, paediatric	<u>43906</u>	carpus, operation for	<u>46462</u>
balloon dilatation of	<u>41832</u>	metacarpal, operation for	<u>46462</u>
dilatation of	<u>41819-41831</u>	phalanx, operation for	<u>46459,46462</u>
intrathoracic operation on, not otherwise covered	<u>38456</u>	skull, craniectomy for	<u>39906</u>
local excision for tumour	<u>30559</u>	Osteoplasty of knee	<u>49503,49506</u>
removal of foreign body in	<u>41825</u>	Osteotomy of accessory bone	<u>48400</u>
Olecranon, excision of bursa of	<u>30110,30111</u>	carpus	<u>48406,48409</u>
fracture, treatment of	<u>47396,47399,47402</u>	clavicle	<u>48406,48409</u>
Omentectomy, infra-colic	<u>35726</u>	femur	<u>48424,48427</u>
with debulking operation	<u>35720</u>	fibula	<u>48406,48409</u>
Oophorectomy, laparoscopic	<u>35638</u>	foot	<u>49833-49838</u>
with laparotomy, not with hysterectomy	<u>35712-35717</u>	humerus	<u>48412,48415</u>
with vaginal hysterectomy	<u>35673</u>	mandible or maxilla	<u>45720-45752</u>
Open heart surgery, not otherwise covered	<u>38653</u>	metatarsal	<u>48400,48403</u>
Operative arteriography or venography	<u>35200</u>	midfacial	<u>45753,45754</u>
cholangiography or pancreatography	<u>30439</u>	pelvic bone	<u>48424</u>
feeding jejunostomy	<u>31462</u>	pelvis	<u>48427</u>
laparoscopy, complicated	<u>35641</u>	phalanx	<u>48400,48403</u>
Ophthalmological examination under GA	<u>42503</u>	radius	<u>48406,48409</u>
Optic fundi, examination of	<u>11212</u>	rib	<u>48406,48409</u>
nerve meninges, incision of	<u>42548</u>	scapula (other than acromion)	<u>48406,48409</u>
Orbit, anophthalmic, insertion of cartilage or implant	<u>42518</u>	sesamoid bone	<u>48400</u>
anophthalmic, placement of motility integrating peg	<u>42518</u>	tarsus	<u>48406,48409</u>
eye, decompression of	<u>42545</u>	tibia	<u>48418,48421</u>
eye, exenteration of	<u>42536</u>	ulna	<u>48406,48409</u>
eye, exploration of	<u>42530,42533</u>	Otitis media, acute, operation for	<u>41626</u>
eye, exploration, removal tumour/foreign body	<u>42539,42542,42543</u>	Oto-acoustic emission audiometry	<u>11332</u>
eye, skin graft to	<u>42524</u>	Oval window surgery	<u>41615</u>
Orbital cavity, bone or cartilage graft to	<u>45593</u>	Ovarian biopsy by laparoscopy	<u>35637</u>
cavity, reconstruction of	<u>45590</u>	cyst aspiration	<u>35518</u>
contents, ultrasonic echography of	<u>11240,11241,11242,11243</u>	cyst, excision of, with hysterectomy	<u>35673</u>
dermoid, congenital, excision of	<u>42574</u>	cyst, excision of, with laparotomy	<u>35712-35717</u>
dystopia, correction of	<u>45776,45779</u>	cyst, puncture of, via laparoscope	<u>35637</u>
implant, enucleation of eye	<u>42506,42509</u>	cystectomy, laparoscopic	<u>35638</u>
implant, evisceration of eye and insertion of	<u>42515</u>	transposition with hysterectomy for malignancy	<u>35729</u>
Orbitotomy	<u>42530,42533</u>	tumour, radical or debulking operation for	<u>35720</u>
Orchidectomy	<u>30638,30641</u>	Ovaries, prolapse, operation for	<u>30387</u>
Orchidopexy for undescended testis	<u>37803,37806,37809</u>	Oxycephaly, cranial vault reconstruction for	<u>45785</u>
Oro-antral fistula, plastic closure of	<u>41722</u>	Oxygen consumption, estimation of	<u>11503</u>
pin or wire, insertion of	<u>47921</u>	therapy, hyperbaric	<u>13020,13025,13030</u>
Oro-nasal fistula, plastic closure of	<u>45714</u>		
Orthopaedic pin or wire, insertion of	<u>47921</u>	P	
ring fixator, adjustment of	<u>50309</u>	Pacemaker electrode, permanent, insertion, sub-xyphoid	<u>38473</u>
Osseo-integration procedures	<u>45794,45797</u>	gracilis neosphincter	<u>32210</u>
Ossicular chain reconstruction	<u>41539,41542</u>		

* Payable on attendance basis

Service	Item	Service	Item
implanted, testing of	11718,11721	ductus arteriosus, division/ligation	38700,38703
permanent, insertion or replacement	38281	urachus, excision of	37800
Pacemaking electrode, temporary transvenous, insertion	38256	Pectus carinatum, repair or radical correction	38457
Palate, cleft, repair of	45707,45710,45713	excavatum, repair or radical correction	38457,38458
Palmar warts, removal of	30186,30187	Pedicle, tubed, or indirect flap	45230
Palpebral ligament, medial, ruptured, repair of	42854	- delay of	
lobe of lacrimal gland, excision of	42593	- formation of	45227
Pancreas, drainage of	30375	- preparation of site and attachment to site	45233
excision of	30583	- spreading of pedicle	45236
Pancreatectomy	30583,30593,30594	Pelvi-ureteric junction, plastic procedures to	36564
Pancreatic abscess, laparotomy and external drainage of	30575	cystoscopy of	36825
cyst, anastomosis to Roux loop of jejunum	30587	Pelvic abscess, drainage via rectum or vagina	30223
cyst, anastomosis to stomach or duodenum	30586	abscess, laparotomy for drainage of	30394
juice, collection of	30488	bone, operation on, for osteomyelitis	43509,43518
necrosectomy	30577	bone, osteectomy or osteotomy of	48424,48427
Pancreatico-duodenectomy (Whipple's operation)	30584	floor abnormalities, diagnosis of	11830,11833
Pancreatico-jejunostomy	30589,30590	haematoma, drainage of	30387
Pancreato-cholangiography, endoscopic	30484	lymph glands, excision of	35551,35664,35670
Pancreatography, operative	30439	ring, fracture, treatment of	47474-47489
Panendoscopy	30473,30476,30478	Pelvic lymphadenectomy	36502
Panhysterectomy	35664	Pelvis, bone graft/shelf procedure, acetabular dysplasia	50393
Pannus, treatment of, with cautery of conjunctiva	42677	fracture, treatment of	47474-47510
Papilloma, bladder, transurethral resection	36839,36845	osteotomy or osteectomy of	48424,48427
larynx, removal of	41852	Penicillin, injection of	*
removal of (see tumour , other)		Penile warts, cystoscopy for treatment of	36815
Papillomata, juvenile, removal with microlaryngoscopy	41858	Penis, amputation of	37402,37405
removal of by laser surgery	41861	artificial erection device, insertion	37426,37429
Papules, electrosurgical destruction or chemotherapy of	*	artificial erection device, revision or removal of	37432
Para-oesophageal, hiatus hernia, repair of	31468	circumcision of	30653-30660
Paracentesis abdominis	30406	correction of chordee	37417,37418
anterior or posterior chamber or both	42740	frenuloplasty	37435
in relation to eye	42734	injection for impotence	37415
of pericardium	38406	lengthening by translocation of corpora	37423
of tympanum	41626	paraphimosis, reduction of under GA	30666
thoracic cavity	38403	partial amputation of	37402
Paralysis, facial nerve, plastic operations for	45575,45578	repair of avulsion	37411
Parapharyngeal tumour, excision of	31409,31412	repair of laceration of cavernous tissue, or fracture	37408
Paraphimosis, reduction of under GA	30666	surgery for penile drainage causing impotence	37420
Parathyroid operation for hyperparathyroidism	30315	Peptic ulcer, bleeding, control of	30505-30509
Paretic states, eyebrows, elevation of	42872	ulcer, perforated, suture of	30375
Parks' intersphincteric operation	32126	Per anal release, rectal stricture	32114
Paronychia of foot, incision for	47912	Perchlorate discharge study	12521
of hand, incision for	46525	Percutaneous aspiration biopsy of deep organ	30094
Parotid duct, diathermy or dilatation	30262	cordotomy	39121
duct, meatotomy or marsupialisation	30265,30266	drainage of deep abscess, imaging guided	30224
duct, removal of calculus	30265,30266	endoscopic gastrostomy	30481,30482
duct, repair of,	30246	epidural electrode, insertion	39130
fistula, repair of	30269	epidural electrodes, management of	39131
gland, superficial lobectomy/removal of tumour	30253	epidural implant, removal	39136
gland, total extirpation of	30247,30250	gastrostomy tube, jejunal extension	31460
tumour, excision of	30251	liver biopsy	30409
Parovarian cyst, removal of	35712-35717	lumbar discectomy	48636
Patch angioplasty for vein stenosis	34815	needle biopsy of lung	38412
grafting to artery or vein	33545,33548	neurotomy for facet joint denervation	39118
testing, epicutaneous	12012-12021	neurotomy of peripheral nerves	39323
Patella, bursa, excision of	30110,30111	neurotomy of spinal nerves	39115
congenital dislocation, reconstruction of quadriceps	50420	transhepatic cholangiogram, imaging guided	30440
dislocation, treatment of	47057,47060	Perforated duodenal ulcer, suture of	30375
fracture, treatment of	47579,47582,47585	gastric ulcer, suture of	30375
Patellar bursa, excision of	30110,30111	peptic ulcer, suture of	30375
Patellectomy	49503,49506	Perforating wound of eyeball, repair of	42551,42554,42557
Patello-femoral stabilisation	49503,49506,49564	Perfusion of donor kidney, continuous	22055
stabilisation, revision of	49548	of limb or organ	22055
Patent diseased coronary bypass vein graft, dissection	38637	retrograde, cerebral (if performed)	22075

* Payable on attendance basis

Service	Item	Service	Item
retrograde, intravenous, sympatholytic agent whole body	14209 22060	pouch, removal of	41770
Perianal abscess, drainage of	32174 , 32175	Pharyngectomy, partial	41782 , 41785
abscess, incision with drainage	30223	Pharyngoplasty	45716
tag, removal of, without GA	*	Pharyngotomy (lateral)	41779
thrombosis, incision of	32147	Pharynx, cauterisation or diathermy	41674
Pericardectomy	38447 , 38449	removal of foreign body from	30061
Pericardium, drainage of, sub-xyphoid	38452	Phlebotomy	*
drainage of, transthoracic	38450	Phonoangiography, carotid vessels	11618 , 11621 , 11624
paracentesis of	38406	Phonocardiography	11706
Perimetry, quantitative	*	Photocoagulation, laser, vascular lesions	14100 - 14132
quantitative, computerised	11221 - 11225	of xenon arc	42782 , 42783
Perineal anoplasty, ano-rectal malformation	43960	Photoiridosyneresis, laser	42808
biopsy of prostate	37212	Photomydriasis, laser	42807
graciloplasty	32203 , 32209	Phototherapeutic, keratectomy	42810
graciloplasty, insert. stimulator & electrode	32209	Physician, consultant, attendance by	(see attendances)
prostatectomy	37200	Pigeon chest, correction of	38457
recto-sigmoidectomy for rectal prolapse	32112	Pilonidal cyst or sinus, excision of	30675 , 30676
repair of rectocele	32131	sinus, injection of sclerosant fluid	30679
repair, rectal prolapse	32120	Pin, orthopaedic, insertion of	47921
stimulation maximal, electrical	*	wire or screw, buried, removal of	47924 , 47927
stimulation maximal, for stress incontinence	*	Pinealoma, craniotomy for removal of	39712
Perineorrhaphy	35576	Pinguecula, removal of	42689
and anterior colporrhaphy	35580	Pinhole urinary meatus, dilatation of	37300
Perinephric abscess, drainage of	36537	Pirogoff's amputation of foot	44361
area, exploration of	36537	Pitangy abdominoplasty	30177
Periorbital correction of Treacher Collins Syndrome	45773	Pituitary tumour, removal of	39715
Doppler examination, carotid vessels	11618 , 11621 , 11624	Placement of catheters and injection of opaque material	
dermoid, congenital, excision of	42573	Placenta, retained, evacuation of	16564
Peripheral arterial atherectomy	35312	ultrasonic localisation by Doppler	*
arterial catheterisation	35321	Placentography, preparation for	36800
cannulation for cardiopulmonary bypass	38603	Plantar fasciotomy, radical	49854
laser angioplasty	35315	warts, removal of	30186 , 30187
nerve, neurectomy/neuromy/tumour	39324 , 39327	Plaster jacket, application of, to spine	47708
venous catheterisation	35317 , 35319 , 35320	Plastic procedures to pelvi-ureteric junction	36564
vessels, examination of	11603 - 11612	reconstruction for bicornuate uterus	35680
Peritomy, conjunctival	42632	reconstruction of lacrimal canaliculus	42602
Peritoneal adhesions, division, with laparotomy	30376 , 30378 , 30379	repair, direct flap	45209 - 45224
biopsies, multiple, with infracolic omentectomy	35726	repair, of cervical oesophagostomy	30293
catheter, insertion and fixation of	13109	repair, single stage, local flap	45200 , 45203 , 45206
catheter, removal of	13110	repair, to enlarge vaginal orifice	35569
dialysis	13112	Plate, rod or nail, removal of	47930
Peritoneo venous (Leveen) shunt, insertion of	30408	Plethysmography	11603 - 11612
Peritoneoscopy	(see laparoscopy)	Pleura, percutaneous biopsy of	30090
Peritonitis, laparotomy for	30394	Pleural effusion	38403
Peritonsillar abscess, incision of	41807	Pleurectomy with thoracotomy	38424
Periurethral injection for urinary incontinence	37339	Pleurodesis with thoracotomy	38424
Perthes, hips or knees, application of cast under GA	50390	Plexus, brachial, exploration of	39333
Petro-clival and clival tumour, removal of	39653 , 39654 , 39656	Plication, intestinal, with enterolysis, Noble type	30375
Peyronie's plaque, operation for	37417	Pneumonectomy	38438 , 38441
Phalanges, amputation/splitting, congenital abnormalities	50396	Poison, ingested, gastric-lavage in the treatment of	14200
Phalanx, bone grafting of, for pseudarthrosis	46402 , 46405	Polycythemia	13757
distal, for osteomyelitis	46459	Polyhydramnios, attendance, not routine antenatal	16502
finger or thumb, fractures, treatment of	47300 - 47333	Polyp, anal, excision of	32142 , 32145
middle or proximal, for osteomyelitis	46462	aural, removal of	41506 , 41509
operation for acute osteomyelitis	43500	cervix, removal of	35611
operation for chronic osteomyelitis	43512	larynx, removal of	41852
osteectomy or osteotomy of	46399 , 48400 , 48403	nasal, removal of	41662 , 41665 , 41668
toe, fracture, treatment of	47663 - 47678	rectal, removal with sigmoidoscopy	32078 , 32081
Pharyngeal adhesions, division of	41758	uterus, removal of	35639 , 35640
bands or lingual tonsils, removal of	41804	Polypectomy, with hysteroscopy	35633
cysts, removal of	41813	Popliteal artery, exploration of, for popliteal entrapment	34145
flap for velo-pharyngeal incompetence	45716	vessel, ligation or exploration, other	34103
pouch, endoscopic resection (Dohleman's op)	41773	Porta hepatitis, radical resection for carcinoma	30461
		Portacath, laparotomy with insertion of	30400

* Payable on attendance basis

Service	Item	Service	Item
Portal hypertension, operations for	30602-30606	Prostatectomy, endoscopic	37203,37206
Porto caval shunt for portal hypertension	30602	open	37200
Portoenterostomy for biliary atresia	43978	radical	37210,37211
Posterior chamber, removal of silicone oil	42815	Prostatic abscess, endoscopic drainage of	37221
sclerotomy	42734	abscess, open drainage of	37212
spinal fusion	40321,40324,40327	coil, insertion of	37223
vaginal repair	35576,35580	Prosthesis, breast, manipulation fibrous tissue surrounding *	
Postero-lateral bone graft to spine	48648,48651	breast, removal and/or replacement	45548-45555
Postnasal space, examination under GA	41653	knee, removal of	49515
space, direct examination with/without biopsy	41761	oesophageal, insertion of	30490
Postnatal care	16564-16573	shoulder, removal of	48927
Postoperative haemorrhage	30058	Provocative test for glaucoma	11200
- control under GA, independent	30058	Pseudarthrosis, bone grafting of metatarsal for	46402,46405
- laparotomy for control of	30385	bone grafting of phalanx for	46402,46405
- tonsils/adenoids, arrest, under GA	41796,41797	Psychiatry, by consultant psychiatrists	(see attendances)
following gynaecological surgery, under GA	35759	Psychotherapy, by consultant psychiatrists	(see attendances)
pain, control of	18206-18212	Pterygium, removal of	42686
Postpartum haemorrhage, treatment of	16567	Ptosis of eyelid, correction of	45623,45624,45625
Pre-auricular sinus, excision of	30104	breast, correction of (unilateral)	45556,45557
Preeclampsia, treatment of	16509	Public health physicians - attendances	410-417
Pregnancy, attendance for complication by	16508	Pudendal and spinal nerve motor latency, measurement	11833
- acute intercurrent infection		Pulmonary artery, banding of	38715,38718
- diabetes or anaemia	16502	artery catheterisation	13818
- intrauterine growth retardation	16508	artery pressure monitoring, open heart	11627
- threatened premature labour	16502,16508	-under 12 years of age	
multiple, attendance other than routine antenatal	16502	decortication with thoracotomy	38421
Premalignant skin lesions, treatment of	30192	Pulp space infection of foot, incision for	47912
Premature labour, attendances not routine antenatal	16502,16508	space infection of hand, incision for	46525
Preoperative examination for anaesthesia	17603	Pulse generator, subcutaneous placement	39134
Prepuce, breakdown of adhesions of *		Pump or reservoir, loading of	14218
operations on	30653-30666	implanted, associated with adjustable gastric band	31441
Presacral and sacrococcygeal tumour, excision of	32036	Punch biopsy of synovial membrane	30087
sympathectomy	35012	Punctum, occlusion of	42620,42621,42622
Pressure monitoring, intracranial	13830	snip operation	42617
monitoring, intravascular	13876	Purse string ligation, cervix	16511
Priapism, decompression of	37393	string ligature of cervix, removal	16512
shunt operation for	37396	Puva therapy	14050,14053
Primary repair of cutaneous nerve	39300	Pyelography retrograde, preparation for	36824
repair of extensor tendon of hand or wrist	46420	Pyelolithotomy	36540,36543
repair of flexor tendon of hand or wrist	46426,46432	Pyeloplasty, by open exposure	36564,36567,36570
repair of nerve trunk	39306	Pyeloscopy, retrograde, of one collecting system	36652,36654,36656
restoration of alimentary continuity	41843	Pyelostomy, open	36552
Proctectomy, perineal	32047	Pyloromyotomy for pyloric stenosis	43930
Proctocolectomy with ileostomy	32015,32018,32021	Pyloroplasty	30375
Proctoscopy *		reconstruction of	30517
Products of conception, retained, evacuation of	16564	Pylorus, dilation of, with vagotomy	30502
Professional attendances	(see attendance)	Pyogenic granulation, cauterisation of *	
Profilometry, urethral pressure	11906,11909	Pyonephrosis, drainage of	36537
Progesterone implant	14203,14206	placement of catheters and injection of opaque material	38243,38220
Prolapse, genital, operations for	35576,35580,35584		
ovaries, operation for	30387	Q	
rectum, abdominal rectopexy	32117	Quadriceps, patella, reconstruction, congenital dislocation	50420
rectum, perineal repair of	32120	Quadricepsplasty, for knee mobilisation	49569
rectum, reduction of *		Quinsy, incision of	41807
rectum, rubber band ligation of	32135		
rectum, sclerotherapy for	32132	R	
urethra, excision of	37369	Radial vessel, ligation or exploration, other	34106
urethra, operation for	35587	Radiation dosimetry	15518-15536
Prolonged professional attendance, lifesaving	160-164	field setting	15500-15515
Proof puncture of maxillary antrum	41698,41701	oncology treatment	15203-15214
Prostate, biopsy of	37212-37219	proctitis, anorectal application of formalin	32212
endoscopic laser ablation	37207,37208	Radioactive B12 absorption test	12512,12515
total excision of	37209,37210,37211		
transurethral radio-frequency needle ablation	37201,37202		

* Payable on attendance basis

Service	Item	Service	Item
Radioisotope, therapeutic dose, administration of	16003-16012	Retina, cryotherapy of	42728,42818
Radiosurgery, stereotactic	15600	detached, diathermy or cryotherapy for	42773
Radiotherapy, deep or orthovoltage	15100-15115	detached, removal of encircling silicone band	42812
planning	15500-15536	detached, resection or buckling operation for	42776
radioactive sources, sealed	15303-15357	detached, revision operation for	42779
radioactive sources, unsealed	16003-16018	light coagulation for	42782,42783
superficial	15000-15012	photocoagulation of	42809
Radioulnar joint, dislocation, treatment of	47024,47027	pre-detachment of, cryotherapy for	42818
joint, distal, reconstruction/stabilisation	46345	Retinal photography	11215,11218
joint, distal, synovectomy	46342	Retrolabial abscess, operation for	42572
Radius, bone graft to	48218-48227	injection of alcohol	42824
fracture, treatment of	47360-47408	transillumination	42821
operation on, for acute osteomyelitis	43503	Retrolabyrinthine vestibular nerve section	41596
operation on, for chronic osteomyelitis	43512	Retroperitoneal abscess, drainage of	30402
osteectomy or osteotomy of	48406,48409	lymph node biopsies	35723
Ranula, removal of	30282,30283	lymph node dissection	37607,37610
Rectal biopsy, full thickness	32096	neuroendocrine tumour, removal of	30321,30323
fistula, closure of	37038,37336	tumour, removal of	30321,30323
polyp, removal of with sigmoidoscopy	32078,32081	Retropharyngeal abscess, incision with drainage	30223
prolapse, Delorme procedure for	32111	Retropubic prostatectomy	37200
prolapse, abdominal rectopexy of	32117	Retroversion, operation for	35683,35684
prolapse, paediatric, injection under GA	44105	Rhinophyma, carbon dioxide laser ablation/excision	45652
prolapse, perineal recto-sigmoidectomy for	32112	shaving of	45653
prolapse, perineal repair of	32120	Rhinoplasty procedures	45632-45644
prolapse, reduction of	*	secondary revision of	45650
prolapse, rubber band ligation of	32135	Rhinotomy, lateral, with removal of tumour	41728
prolapse, sclerotherapy for	32132	Rhizolysis, spinal	40330
stricture, dilatation of	32115	Rib, cervical, removal of	34139
stricture, per anal release of	32114	first, resection of portion	34136
tumour, excision of	32099,32102,32108	fracture, treatment of	47471
Rectocele, perineal repair of	32131	operation for acute osteomyelitis	43503
vaginal repair of	35576,35580	operation for chronic osteomyelitis	43512
Rectopexy, abdominal, of rectal prolapse	32117	osteectomy or osteotomy of	48406,48409
Rectosigmoidectomy (Hartmann's operation)	32030	resection, with radical operation for empyema	38415
perineal, for rectal prolapse	32112	Ring fixator, adjustment of	50309
Rectosphincteric reflex, measurement of	11830	Rod, plate or nail, removal of	47930
Rectovaginal fistula, repair of	35596	Rodent ulcer, operation for	(see ulcer , other)
Rectum and anus, abdomino-perineal resection of	32039-32046	Rosen incision, myringoplasty	41527
anterior resection of	32024-32028	Rotator cuff of shoulder, repair of	48906,48909
examination under GA, paediatric	44102	Round window repair or cochleotomy	41614
perineal resection of	32047	Roux-en-Y biliary bypass	30460,30466,30467
suction biopsy of	30071	Rovsing's operation	36537
Recurrent hernia, repair of	30403	Rubin test for patency of Fallopian tubes	35706
Reduction mammoplasty (unilateral)	45520	Ruptured medial palpebral ligament, repair of	42854
with surgical repositioning of nipple	45520	membranes, threatened premature labour	16508
without surgical repositioning of nipple	45522	muscle, repair of	30232,30235
Reduction ureteroplasty	36618	thoracic aorta, operative management of	38572
Refitting of contact lenses	10816	urethra, repair of	37306,37309
Reflux, gastro-oesophageal, correction	43951,43954,43957	viscus, major repair or removal of	30375
vesico-ureteric, correction	36588		
Refractive keratoplasty	42671		
Regional nerve block	(see nerve)		
Regitine phentolamine test for pheochromocytoma	*		
Renal artery, aberrant, operation for	36537	Sacral sinus, excision of	30675,30676
biopsy (closed)	36561	sympathectomy	35012
cyst, excision of	36558	Sacro-iliac joint, arthrodesis of	49300
dialysis in hospital	13100,13103	joint disruption, treatment of	47513
function test	12524,12527	Sacrococcygeal and presacral tumour, excision of	32036
pelvis, brush biopsy of, with cystoscopy	36821	teratoma, neonatal, excision of	43876,43879
transplant	36503,36506,36509	Salivary gland, major, transposition of duct	41910
Resevoir, implanted associated with gastric band	14215,31441	gland, operations on	30262-30269
or pump, loading of	14218	Salpingectomy, laparoscopic	35638
Respiratory function, estimation of	11503-11512	with laparotomy, not with hysterectomy	35712-35717
Resuturing of wound following intraocular procedures	42857	with vaginal hysterectomy	35673
		Salpingo-oophorectomy not with hysterectomy	35712-35717

* Payable on attendance basis

Service	Item	Service	Item
Salpingolysis	35694,35697	Shoulder, amputation or disarticulation at	44331
Salpingostomy	35694,35697	Stabilisation procedure for recurrent anterior or posterior	
laparoscopic	35638	dislocation	48930
Saphenous vein anastomosis	34809	arthrectomy or arthrodesis	48939,48942
Scalene node biopsy	30096	arthroscopic surgery	48948-48960
Scalenotomy	34133	arthroscopy	48945
Scalp vein catheterisation in a neonate	13300	arthrotomy	48912
Scaphoid, bone graft to	48230,48233,48236	dislocation, treatment of	47009,47012,47015
Scapula, fracture, treatment of	47468	hemi-arthroplasty of	48915
(other than acromion), osteectomy/osteotomy	48406,48409	nerve block for post op pain	18212
operation for chronic osteomyelitis	43512	open reduction for congenital dislocation	50408
Scar, abrasive therapy to	45021,45024	orthopaedic treatment of	48900,48903
face or neck, revision of (restriction applies)	45506,45512	prosthesis, removal of	48927
other than face or neck, revision of (restriction)	45515,45518	removal of calcium deposit from cuff	48900
other, removal of	31200-31240	rotator cuff, repair of	48906,48909
Scars, corneal, removal of, by partial keratectomy	42647	spica, application of	47540
Schilling test	12512,12515	stabilisation, for multidirection instability	48933
Sclera, removal of imbedded foreign body	42644	synovectomy of	48936
removal of superficial foreign body	30061	total replacement of	48918,48921,48924
transplantation of	42662,42665	Shunt, aorto-pulmonary or cavo-pulmonary	38733,38736
Scleral blood vessels, laser coagulations of	42797	arteriovenous, external, insertion/removal	34500,34506
graft to lid	42860	cranial or cisternal, insertion of	40003
Sclerectomy and iridectomy for glaucoma	42746	cranial or cisternal, revision or removal of	40009
Sclerosant fluid, injection of into pilonidal sinus	30679	lumbar, insertion of	40006
injection of starburst vessels, head/neck	30213,30214	lumbar, revision or removal of	40009
injection of telangiectases, head/neck	30213,30214	Sigmoidoscopic examination	32072,32075
Scoliosis, anterior correction of (Dwyer procedure)	48621,48624	- with diathermy or resection of polyp/s	32078,32081
application of halo	47714	Sigmoidoscopy, fiberoptic, flexible	32084,32087
congenital, vertebral resection and fusion for	48632	Silicone band, encircling, removal from detached retina	42812
re-exploration for	48615	breast prosthesis, removal of	45555
requiring anterior decompression of spinal cord	48630	Sinoscopy	41764
revision of failed surgery	48618	Sinus, diathermy of	*
spinal fusion for	48606-48613	ethmoidal, external operation on	41749
spinal fusion for, with segmental instrumentation	48627	excision of	30099,30102,30103
spinal fusion with use of Harrington rod	48681	frontal, catheterisation of	41740
Screw, pin or wire, buried, removal of	47924,47927	frontal, radical obliteration of	41746
Scrotal contents, exploration of	37604	frontal, trephine of	41743
Scrotum, excision of abscess of	30223	injection of sclerosant fluid under anaesthesia	30679
partial excision of	37438	intranasal operation on	41737
Sebaceous cyst, removal of	(see cyst,other)	maxillary, drainage of, through tooth socket	41719
Second trimester labour, management of	16525	pilonidal, excision of	30675,30676
Secondary, repair of extensor tendon of hand or wrist	46423	pre-auricular, excision of	30104
repair of flexor tendon of hand or wrist	46429	sphenoidal, intranasal operation on	41752
Segmentectomy	38438	urogenital, vaginal reconstruction for	35565
Semen, collection of	13290,13292	Skin, biopsy of	30071
Semimembranosus bursa, excision of	30114	cancer, treatment of	30196-30205
Seminal vesicle/ampulla of vas, total excision of	37209	full face chemical peel	45019,45020
Sengstaken-Blakemore tube, insertion of	13506	graft to orbit	42524
Septal defect, atrial, closure of	38742	grafts	(see graft)
defect, ventricular, closure of	38751	lesions, multiple injections for	30207
perforation, closure of	41671	lesions, treatment of	30192,30195
Septectomy, cardiac	38739,38748	malignant lesion, removal of	31300-31335
Septoplasty of nasal septum	41671	repair of recent wound of	30026-30049
Septostomy, or balloon valvuloplasty	38270	sensitivity testing for allergens	12000,12003
Septum button, nasal, insertion of	41907	subcutaneous tissue, extensive excision	31245
nasal, cauterisation/diathermy	41674	tags, anal, excision of	32142,32145
nasal, reconstruction of	41672	Skull base surgery for tumour removal	39640-39662
nasal, septoplasty or submucous resection	41671	base tumour, removal, infra-temporal	41581
vaginal, excision of, for correction of double vagina	35566	calipers, insertion of	47705
Sequestrectomy	43512-43524	fracture, attendance for treatment of	47703
Seroma, breast, exploration, drainage, operating theatre	31551	fractured, operations for	39606-39615
Sesamoid bone, osteotomy or osteectomy of	48400	osteomyelitis, acute, operation for	43503
Seton, readjustment of, in anal fistula	32166	osteomyelitis, chronic, operation for	43521
Shirodkar suture	16511	osteomyelitis, craniectomy for	39906

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Service	Item	Service	Item
treatment of fracture, not requiring operation	47703	Sports physicians, attendances by medical practitioners who are sports physicians	444-449
tumour, excision of	39700	Squamous cell carcinoma, removal of	31255-31295
Sleep apnoea, overnight investigation for	12203,12207	Squint, muscle transplant (Hummelsheim type)	42848
Overnight paediatric investigation	12210,12213,12215,12217	operation for	42833-42842
Sling operation for stress incontinence	35599	readjustment of adjustable sutures	42845
procedure, intestinal, prior to radiotherapy	32183	recurrent, operation for	42851
Slough, debridement of	35100,35103	Staging laparotomy for gynaecological malignancy	35726
Small bone, exostosis, excision of	47933	Stapedectomy	41608
bowel intubation	30487,30488	Stapes mobilisation	41611
bowel strictureplasty	30564	Staple arrest of hemi-epiphysis	48509
bowel, endoscopic examination of	32095	Starburst vessels, head/neck, diathermy or injection	30213,30214
intestine, resection of	30565,30566	Stenosing tendovaginitis, hand/wrist, open operation	46363
Smith's fracture of radius, treatment of	47369,47372,47375	Stenosis, arteriovenous fistula/access device, correction of	34518
Smith-Petersen nail, removal of	47924,47927	auditory canal, correction of	41521
Socket, eye, contracted, reconstruction of	42527	spinal, laminectomy for	40303,40306
Specialist attendance	(see attendance)	tracheal, dilatation of, with bronchoscopy	41904
Specimen of sweat, collection of, by iontophoresis	12200	venous, operations for	34812,34815
Speech discrimination tests	11321	Stent, external, application restore valve competency	34824-34833
Spermatic cord, exploration of, inguinal approach	30644	insertion, transluminal	35306,35309,35310
Spermatocele, excision of	37601	ureteric, passage through nephrostomy tube	36604
Sphenoidal sinus, intranasal operation on	41752	Stereotactic procedures	40800,40801,40803
Sphincter, anal, direct repair of	32129	radiosurgery	
anal, stretching of	32153	Sterilisation (female)	35687,35688
bladder, endoscopic incision/resection	36854	in conjunction with Caesarean section	35691
muscle and pelvic floor abnormalities, diagnosis of	11833	Sternal wire/s, removal of	38460
of Oddi, transduodenal operation on	30458	Sternocleidomastoid muscle, bipolar release, torticollis	50402
urethral, reconstruction	37375	Sternotomy for removal of thymus or mediastinal tumour	38446
urinary, artificial, insertion	37381,37384,37387	involving division of adhesions	38643,38647
urinary, artificial, revision or removal	37390	median, for post-operative bleeding	38656
Sphincterotomy, anal, independent procedure	43999	wound, debridement of	38462,38464
endoscopic	30485,36854	Sternum and mediastinum, reoperation for infection	38468,38469
Spinal and pudendal nerve motor latency, measurement	11833	biopsy of	30081,30087,30084
catheter and subcutaneous reservoir, insertion of	39127	fracture, treatment of	47466,47467
catheter, insertion of for infusion device	39125,39128	operation for acute osteomyelitis	43503
cord, cervical decompression	40331-40335	operation for chronic osteomyelitis	43512
fusion to cervical, thoracic or lumbar regions	48660-48675	reoperation for dehiscence or infection	38466
fusion, application of halo for scoliosis	47714	Stomach lavage	*
fusion, posterior	40321,40324,40327	lavage in the treatment of ingested poison	14200
fusion, posterior interbody, with laminectomy	48654,48657	Stone/s, biliary/renal tract, extraction of	(see calculus)
nerves, injection into	39013	removal of, by urethroscopy	36540,36543
nerves, percutaneous neurotomy	39115	Strabismus, injection of botulinus toxin for	42830
neurostimulator receiver, subcutaneous placement	39134	operation for	42833,42839
rhizolysis	40330	Stress incontinence, abdomino-vaginal operation	35602,35605
shunt for hydrocephalus	40006	incontinence, Marshall-Marchetti, urethropexy	35599,37044
stenosis, laminectomy for	40303,40306	incontinence, sling operation	35599
thoracic decompression	40345,40348	incontinence, treatment by maximal perineal stimulation	*
thoraco-lumbar/high lumbar decompression	40351	incontinence, vaginal procedure for	35600
using segmental instrumentation	48613	Stricture, anal, anoplasty for	32123
Spine, application of plaster jacket to	47708	oesophagus, dilatation of	41819
bone graft to	48642-48651	rectal, dilatation of	32115
fracture, treatment of	47681-47702	rectum, plastic operation to	30387
internal fixation of	48678-48690	tracheal, dilatation of, with bronchoscopy	41904
manipulation of	48600,48603	urethral, dilatation of	37303
operation on, for acute osteomyelitis	43509	Strictureplasty, small bowel	30564
operation on, for chronic osteomyelitis	43518	Strontium 89, administration of	16015
Spirometry	11506,11509	Stump, amputation, reamputation of	44376
Spleen, ruptured, repair or removal of	30375	amputation, trimming of	*
Splenectomy	30597,30599	cervix-residual, removal of, abdominal approach	35612
laparoscopic	31470	cervix-residual, removal of, vaginal approach	35613
Spleno renal shunt, selective, for portal hypertension	30605	Styloid process of temporal bone, removal of	30244
Splenorrhaphy	30596	Sub-valvular structures, heart, reconstruction, re-implant	38490
Split skin free grafts, granulating areas	45400,45403	Subclavian artery, endarterectomy	33506
skin free grafts to one defect	45439-45448	to femoral bypass grafting	32715

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Service	Item	Service	Item
vessel, ligation/exploration, other	34103	Talipes equinovarus, cast/manipulation/splint	49878
Subcutaneous fasciotomy, Dupuytren's contracture	46366	equinovarus, procedures for	50315-50330
fistula in ano, excision of	32156	Talus fracture, treatment of	47606-47618
foreign body, removal not otherwise covered	30064	vertical, congenital, reconstruction	50336
reservoir and spinal catheter, insertion of	39127	Tarsal cartilage, excision of	42578
tenotomy	47960	cauterisation of, for ectropion or entropion	42581
tissue, repair of recent wound of	30026-30049	coalition, excision of	50333
Subdural haemorrhage, tap for	39009	cyst, extirpation of	42575
Sublingual gland, duct, removal of calculus	30265,30266	Tarsometatarsal joint, fracture, treatment of	47621,47624
gland, extirpation of	30259	joint, Lisfranc's amputation of	44364
gland, meatotomy or marsupialisation	30265,30266	Tarsorrhaphy	42584
Submandibular abscess, incision of	30223	Tarsus, dislocation, treatment of	47063,47066
ducts, relocation of	30255	fracture, treatment of	47627,47630
gland, extirpation of	30256	operation on, for acute osteomyelitis	43503
Submaxillary gland, repair of cutaneous fistula	30269	operation on, for chronic osteomyelitis	43512
Submucous resection of nasal septum	41671	osteotomy or osteotomy of	48406,48409
resection of turbinates	41692	Tear duct, probing of	42610-42615
Subperiosteal abscess	43500-43524	third degree, repair of	16573
Subphrenic abscess, laparotomy for drainage of	30394	Teflon injection, into vocal cord	41870
Subtalar arthrodesis	50118	injection, peri-urethral	37339
Subtemporal decompression	40015	Telangiectases, head/neck, diathermy or injection of	30213,30214
Subungual haematoma, incision of	30219	Temperature, digital, measurement of	11615
Suction biopsy of rectum	30071	Temporal artery, biopsy of	34109
curettage of uterus	35639,35640,35643	bone, reconstruction of	45788
Supraglottic laryngectomy with tracheostomy	41840	bone, removal of styloid process of	30244
Suprapubic cystostomy or cystotomy	37008	bone, resection for removal of tumour	41584,41587
cystostomy tube, change of	*	Temporo-mandibular joint, arthroplasty	45758
prostatectomy	37200	meniscectomy	45755
stab cystotomy	37011	Temporosphenoidal electroencephalography	11006
Surgical reduction of enlarged elements, macroductyly	46510	Tendon	49718-49727
wounds, resuturing of (not burst abdomen)	*	- Achilles, repair of	49718-49727
Suspension of uterus	35683,35684	- artificial prosthesis, insertion of for grafting	46414
of vaginal vault, abdominal approach	35590	- foot, adductor hallucis, transfer of	49827,49830
Suture, laser division of, eye, following trabeculoplasty	42794	- foot, repair of	49800-49812
shirodakar	16511	- foreign body in, removal	30067,30068
traumatic wounds	30026-30049	- hand/digit, synovectomy of	46336-46360
Sutures, adjustable, readjustment of, for squint	42845	- hand/wrist, repair of	46420-46435
dressing and removal of, requiring GA	30055	- lengthening of	47957,47960,47963
Swann-Ganz catheterisation	13818	- major, of ankle, repair of	49718-49727
Sweat, collection of specimen of, by iontophoresis	12200	- or ligament transfer	47966
gland bearing area, excision of	30180,30183	- prosthesis, artificial, insertion for grafting	46414
Sycosis barbae/nuchae, excision of	31245	- reconstruction of, by tendon graft	46408
Symblepharon, grafting for	45629	- repair of	47954,49718
Syme's amputation of foot	44361	- sheath, open operation for tenovaginitis	46363,47972
Sympathectomy, chemical	(see nerve blocks)	- tenotomy	47960,47963
surgical	35000-35012	- transfer of, to restore elbow function	50405
Symphysis pubis, fracture, treatment of	47474-47489	- transfer of, to restore hand function	46417
Syndactyly, repair	(see flap repair)	- transplantation of	47966
Synechiae, division of	42761	Tenolysis, hand	46450,46453
Synovectomy, of ankle	50312	Tenoplasty	47963
of elbow	49109	Tenosynovectomy	47969
of finger joints	46336	Tenosynovitis, open operation, tendon sheath hand/wrist	46363
of hand tendons	46336,46342	Tenotomy	47960,47963,49806,49809
of joint, not otherwise covered	50104	percutaneous, of finger	46456
of metatarso-phalangeal joint	49860,49863	Tenovaginitis, open operation for	46363,47972
of shoulder	48936	Tensillon test	*
of tendons of digit	46348-46360	Teratoma, mediastinal, thoracotomy and excision	43912
total, of knee	49509	sacrococcygeal, neonatal, excision of	43876,43879
total, of wrist	49224	Testicular implant	45051
Synovial cavity, aspiration of	50124,50125	Testis, exploration of	37604
membrane, punch biopsy of	30087	impalpable, exploration of groin	37812
selective coronary angiography	38215-38246	undescended, orchidopexy for	37803,37806,37809
		Testopexy	37803

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* Payable on attendance basis

Service	Item	Service	Item
Tethered cord, release of	40112	subcutaneous, repair of recent wound of	30026-30049
Thenar spaces of hand, drainage of	46519	Toe, amputation or disarticulation of	44338-44358
Therapeutic haemapheresis	13750	dislocation, treatment of	47069,47072
Therapeutic venesection	13757	fracture, simple, treatment of	*
Thigh, amputation through	44367	fractures, treatment by reduction	47663-47678
hamstring tendon transfer	50357,50360	hammer or claw, correction of	49848,49851
rectus femoris tendon transfer	50357	hyperextension deformity, release, lengthening	50345
Third degree tear, repair of	16573	phalanx of, operation for acute osteomyelitis	43500
ventriculostomy	40012	Toenail, ingrowing, excision or resection for	47915,47916,47918
Thompson arthroplasty of hip	49315	ingrown, operation with GA, paediatric	44136
Thoracic aneurysm, replacement by graft	33103	removal of	47904,47906
aorta, operative management of rupture/dissection	38572	Tongue, partial or complete excision of	30272,41779,41785,41782
aorta, repair or replacement procedures	38550-38571	tie, repair of	30278,30281
cavity, aspiration of	38400,38403	Tonography, one or both eyes	11203
decompression of spinal cord	40345,40348	Tonsils, lingual, removal of	41804
outlet compression, removal operation	34139	or tonsils and adenoids	41796,41797
sympathectomy	35003,35006	- arrest of haemorrhage, requiring GA	
Thoraco-lumbar decompression of spinal cord	40351	- removal of, twelve years or over	41792,41793
Thoracoplasty	38427,38430	- removal of, under twelve years	41788,41789
Thoracoscopy	38436	Topectomy, for epilepsy	40703
Thoracotomy	38418,38421,38424	Torkildsen's operation	40000
and excision of cyst/teratoma	43912	Torticollis, bipolar release sternocleidomastoid muscle	50402
for congenital cystadenomatoid malformation	43861	operation for	44133
for congenital lobar emphysema	43861	Trabeculectomy for glaucoma	42746,42783
for oesophageal atresia, neonatal	43852	Trabeculectomy, laser, of eye	42782
for removal of thymus or mediastinal tumour	38446	Trachea, dilatation of stricture and stent insertion	41905
involving division of adhesions	38643,38647	removal of foreign body from	41886
or median sternotomy for post-operative bleeding	38656	Tracheal excision, repair, with cardiopulmonary bypass	38455
Threatened abortion, treatment of	16505	excision, repair, without cardiopulmonary bypass	38453
miscarriage, purse string ligation of cervix	16511	stricture, dilatation of with bronchoscopy	41904
miscarriage, treatment of	16505	Trachelorrhaphy	35617,35618
premature labour, treatment of	16502,16508	Tracheo-oesophageal fistula, division and repair	43900
Three snip operation	42617	formation of, including endoscopic procedures	41885
Thrombectomy of arteriovenous access device	34515	Tracheomalacia, aortopexy for	43909
of artery or vein	33803,33806,33812	Tracheoplasty or laryngoplasty with tracheostomy	41879
Thrombosis, peri-anal, incision of	32147	Tracheostomy	
reoperation on extremity for	33848	by open exposure of the trachea	41881
Thrombus, removal of	33803,33806,33812	closure of	30102,30103
Thumb, digital nail, removal of	46513,46516	percutaneous technique, sequential dilation, partial splitting	
flexor tendon sheath, open operation	46522	method	41880
fractures, treatment of	47300-47333	using Minitrach or similar device	41884
ingrowing nail, resection	46528,46531	with laryngoplasty or tracheoplasty	41879
nodule, removal of	(see tumour ,other)	with supraglottic laryngectomy	41840
Thymectomy	38456	with vertical hemi-laryngectomy	41837
Thymoma, malignant, removal from mediastinum	38456	Transantral ethmoidectomy with radical antrostomy	41713
Thymus, removal of by thoracotomy or sternotomy	38446	ligation of maxillary artery	41707
Thyroglossal cyst and/or fistula, removal of	30313,30314	vidian neurectomy	41713
Thyroid uptake	12518	Transfusion	13703,13706
Thyroidectomy	30296-30310	collection of blood for	13709
Tibia, bone graft to	48206,48209	paediatric/neonatal	13306,13309
congenital deficiency, treatment of	50417,50423	Transillumination, retrobulbar	42821
congenital pseudarthrosis, resection, fixation	50354	Translabyrinthine vestibular nerve section	41593
epiphyseodesis	48503,48506	Transluminal balloon angioplasty	35300-35305
fracture, treatment of	47543-47573	stent insertion	35306,35309,35310
operation on, for acute osteomyelitis	43503	Transmastoid decompression of endolymphatic sac	41590
operation on, for chronic osteomyelitis	43512	removal of glomus tumour	41623
osteectomy or osteotomy of	48418,48421	Transmetacarpal amputation of hand	44325
Tibial vessel, ligation/exploration not otherwise covered	34106	Transmetatarsal amputation of foot	44364
Tic douloureux, injection for	39100	Transorbital ligation of ethmoidal arteries	41725
Tilt table testing for investigation of syncope	11724	Transplantation, cornea	42653,42656,42659
Tissue expansion for breast reconstruction	45539,45542,45566	ligament or tendon	47966
expansion, intra-operative	45572	ureter	36585-36603
free transfer of	45563	Transposition of digit	46507
living, implantation of	14203,14206	of nerve	39321

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Service	Item	Service	Item
Transthoracic drainage of pericardium	38450	peripheral nerve, removal from	39324,39327
Transtympanic removal of glomus tumour	41620	pituitary, hypophysectomy or removal of	39715
Transurethral injection for urinary incontinence	37339	rectal, excision of	32099,32102,32108
Transvenous electrode/s, permanent, insertion of	38278,38284	removal of, by laminectomy	40309,40318
pacemaking electrode, temporary, insertion of	38256	removal of, by lateral rhinotomy	41728
Treacher Collins Syndrome, peri-orbital correction of	45773	removal of, by temporal bone resection	41584,41587
Trephine of frontal sinus	41743	removal of, by urethrectomy	37330
Trichiasis, treatment of	42587	sacrococcygeal and presacral, excision of	32036
Trichoepitheliomas, face/neck, removal by laser excision	30190	skin, malignant, removal of	31300-31335
Trigeminal gangliotomy, radiofrequency/balloon/glycerol	39109	skin, micrographic serial excision	31000,31001,31002
nerve, injection with alcohol, cortisone etc	39100	skull base, removal of	39640-39662
neuralgia, intracranial neurectomy	39106	skull, excision of	39700
Trigger finger, correction of	46363	spinal, laminectomy for	40318
Tube, indwelling oesophageal, gastrostomy for fixation	30375	thyroid, removal of	30310
insertion of, for drainage of middle ear	41632	vagina, simple, removal of	35557
Tubed pedicle or indirect flap	45230	vocal cord, removal from	41852
- delay of		Turbinates, cauterisation or diathermy of	41674
- formation of	45227	dislocation, treatment of	41686
- preparation of site and attachment to site	45233	submucous resection of	41692
- spreading of pedicle	45236	Turbinectomy	41689
Tuboplasty	35694,35697	Turricephaly, cranial vault reconstruction for	45785
Tumour, adrenal gland, excision of	30324	Tympani, paracentesis of	41626
benign, of soft tissue, removal	31350	Tympanic membrane, micro-inspection of	41650
bladder, diathermy/resection with cystoscopy	36839,36845	membrane, micro-inspection with ear toilet	41647
bladder, laser destruction with cystoscopy	36839	Tympanum, perforation, cauterisation or diathermy	41641
bone, benign, requiring allograft, resection of	50230		
bone, innocent, excision of	30241	U	
bone, malignant, operations for	50200-50239	UVB therapy	14050,14053
broad ligament, removal of	35712-35717	Ulcer, corneal, epithelial debridement for	42650
cardiac, excision of	38670-38680	corneal, ionisation of	*
carotid body, resection of	34148,34151,34154	duodenal, perforated, suture of	30375
cerebello-pontine angle, removal of	41575-41579	gastric, perforated, suture of	30375
endocrine, exploration of	30578,30580,30581	other, removal of	31200-31240
extradural, laminectomy for	40309	peptic, bleeding, control of	30505-30509
face/neck, laser excision	30190	peptic, perforated, suture of	30375
gastric, removal of	30520	Ulna, bone graft to	48218-48227
glomus, removal of	41620,41623	fracture, treatment of	47360-47408
gynaecological, radical or debulking operation	35720	operation on, for acute osteomyelitis	43503
intra-oral, radical excision of	30275	operation on, for chronic osteomyelitis	43512
intra-temporal fossa, removal of	41578	osteotomy or osteotomy of	48406,48409
intracerebral, craniotomy and removal of	39709	Ulnar vessel, ligation/exploration not otherwise covered	34106
intracranial, biopsy/decompression, osteoplastic flap	39706	Ultrasonic localisation of placenta, Doppler technique	*
intracranial, burr-hole biopsy or drainage	39703	Ultrasound, intraoperative, biliary tract	30439
intracranial, craniotomy and removal of	39709,39712	staging of intra-abdominal tumours	30441
intramedullary, laminectomy for	40318	Umbilical artery catheterisation	13303
involving ciliary body an/or iris, excision of	42767	granuloma, excision under GA	43948
iris, excision of	42764	hernia, repair of	30616-30621
larynx, removal of	41852	vein catheterisation in a neonate	13300
limbic, removal of	42692	Undescended testis, orchidopexy for	37803,37806,37809
lipoma, removal of	31345	Unstable lie, attendances other than routine antenatal	16502
malignant of soft tissue, removal of	31355	Upright tilt table testing for syncope	11724
malignant upper aerodigestive tract	31400,31403,31406	Urachus, patent, excision of	37800
malignant, bone, operations for	50200-50239	Urea breath test	12533
malignant, skin, removal of	31300-31335	Ureter, brush biopsy of, with cystoscopy	36821
mandible, segmental resection for	45605	divided, repair of	36573
mediastinal, removal by thoracotomy or sternotomy	38446	exploration of	36612
microlaryngoscopy with removal of	41864	retrocaval, correction of, by open exposure	36564,36567
neuroendocrine, removal of	30321,30323	transplantation of	36597
other, removal of (restriction applies)	31200-31240	- into another ureter	
ovarian, radical or debulking operation for	35720	- into bladder	36588,36591
parapharyngeal, excision of, cervical approach	31409,31412	- into intestine	36594
parathyroid, removal of	30306	- into isolated intestinal segment	36600,36603
parotid gland, removal of	30253	- into skin	36585
parotid, excision of	30251		

* Payable on attendance basis

Service	Item	Service	Item
Ureterectomy	36579	adhesiolysis, with hysteroscopy	35633
Ureteric calculus, endoscopic extraction/manipulation	36857	adhesions, laparoscopic division	35638
catheterisation with cystoscopy	36818,36824	adnexae, removal, with abdominal hysterectomy	35653
dilatation	36821	lavage, (saline flushing)	*
meatotomy	36830	myomectomy	35649
reflux, correction of	36588	septum, hysteroscopic resection	35623
stent, insertion of	36821	tubes, insufflation of, for patency (Rubin test)	35706
stent, removal/replacement of	36825	Utero-sacral ligaments, laparoscopic division	35638
stent, through nephrostomy tube	36604	Uterus, acute inversion, vaginal correction	16570
Ureterolithotomy	36549	bicornuate, plastic reconstruction for	35680
complicated by previous surgery	37444	curetage of	35639,35640
Ureterolysis	36615	debulking prior to vaginal hysterectomy	35658
Ureteroplasty	36618	gravid, evacuation of contents	35643
Ureteroscopy	36803,36806,36809	implantation of Fallopian tubes into	35694,35697
Ureterostomy, cutaneous, closure of	36621	suspension or fixation of	35683,35684
revision of	36609	Uvula, excision of	41810
Urethra, cauterisation of	35523	Uvulectomy and partial palatotomy	41787
diathermy of	37318	Uvulopalatopharyngoplasty	41786
diverticulum, excision of	37372	Uvulotomy	41810
endoscopic examination with cystoscopy	36812		
laser therapy, intraepithelial neoplasia	35539,35542,35545	V	
prolapsed, excision of	35587,37369	Vagina, artificial formation of	35565
ruptured, repair of	37306,37309	dilatation of, as an independent procedure	35554
Urethral abscess, drainage of	30223	laser therapy, intraepithelial neoplasia	35539,35542,35545
caruncle, cauterisation of	35523	partial or complete removal of	35560
caruncle, excision of	35526,35527	removal of simple tumour of	35557
dilatation with cystoscopy	36812	Vaginal correction of acute inversion of uterus	16570
diverticulum, excision of	37372	fistula, repair or closure of	35596,37029,37333
fistula, closure of	37333,37336,37833	hysterectomy	35657,35673
pressure profilometry	11906,11909	orifice, plastic repair to enlarge	35569
prosthesis, with cystoscopy	36811	procedure for stress incontinence	35600
reconstruction, hypospadias/epispadias	37815,37827,37830	reconstruction, congenital absence/gynatresia	35565
sounds, passage of, as an independent procedure	37300	repair, anterior and/or posterior	35576,35580
sphincter, reconstruction of	37375	repair, with sacrospinous colpopexy	35567
stricture, dilatation of	37303	septum, excision for correction of double vagina	35566
stricture, optical urethrotomy for	37327	vault, suspension of, abdominal approach	35590
stricture, plastic repair of	37342-37351	warts, removal under GA or nerve block	35507,35508
tumour, removal of by urethrectomy	37330	Vaginectomy, radical, for malignancy	35561,35562,35564
valves, destruction of	37854	Vaginoplasty for congenital adrenal hyperplasia	37851
warts, cystoscopy for the treatment of	36815	Vagotomy	30496-30503
Urethral sling, division or removal of	37340,37341	Vallecular cysts, removal of	41813
Urethrectomy	37330	Valve annuloplasty, heart	38475,38477,38478
Urethrocele, operation for	35587	leaflet/s, aortic, decalcification of	38483
Urethropexy (Marshall-Marchetti operation)	35599,37044	mitral, open valvotomy of	38487
Urethroplasty	37342-37351	repair, heart	38480,38481
Urethroscopy, as an independent procedure	37315	replacement, heart	38488,38489
with biopsy/diathermy/foreign body/stone	37318	Valvotomy for pulmonary stenosis	38456
with cystoscopy	36812	open, of mitral valve	38487
with cystoscopy and injection for incontinence	37339	Valvuloplasty, balloon or septostomy	38270
with laser destruction of stone	37318	Varicocele, surgical correction of	30634,30635
Urethrostomy	37324	Varicose veins, injection of sclerosing fluid	*
Urethrotomy, external or internal	37324	veins, multiple injections	32500,32501
optical, for urethral stricture	37327	veins, operations for	32500-32517
Urinary conduit or reservoir, endoscopic examination	36860	Vas deferens, operations on	37616-37623
conduit, revision of	36609	Vasectomy	37622,37623
infection, bladder washout test	11921	Vasopididymostomy (unilateral)	37616,37619
reservoir, formation of	36606	Vasotomy	37622,37623
sphincter, artificial	37381,37384	Vasovasotomy	37616,37619
- insertion of cuff		Vein, anastomosis, microsurgical	45502
- insertion of pressure regulating balloon, pump	37387	bypass for venous stenosis or occlusion	34812
- revision or removal of	37390	cannulation of, in a neonate	13300
Urine flow study	11900	central, catheterisation	13318,13319,13815
Urogenital sinus, vaginal reconstruction for	35565	central, catheterisation, subcutaneous tunnel	34527,34528
Uterine adenomyoma, excision of	35649		

* Payable on attendance basis

Service	Item	Service	Item
Z-plasty, in association with Dupuytren's Contracture	46384		
Zinc ionisation of nostrils in the treatment of hay fever	*		
Zygo-apophyseal joint, injection into	39013		
Zygoma, osteotomy or osteectomy of	45720-45752		
Zygomatic arch, reconstruction of	45788		
bone, fracture, treatment of	47762-47771		

* Payable on attendance basis



**ORAL AND MAXILLOFACIAL
SERVICES
BY APPROVED DENTAL
PRACTITIONERS**

CATEGORY 4

PLEASE NOTE:

The information contained in this Category relates specifically to the Medicare Arrangements relating to Services by Approved Dental Practitioners. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category. (The arrangements set out in the INTRODUCTION and GENERAL EXPLANATORY NOTES apply equally to Approved Dental Practitioners)

CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES
(by Approved Dental Practitioners)

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CATEGORY 4 - ORAL AND MAXILLOFACIAL SERVICES

(by Approved Dental Practitioners)

OUTLINE OF ARRANGEMENTS

OA. INTRODUCTION

OA.1 Benefits for Medical Services by Dental Practitioners

Under the provisions of the Health Insurance Act 1973 (the Act), Medicare benefits are payable where an eligible person incurs medical expenses in respect of certain professional services rendered by an approved dental practitioner. Approved dental practitioners may also request certain diagnostic imaging services (see paragraph DIA.4.8 of Category 5 Explanatory Notes).

Details of the services attracting Medicare benefits are set out in the Schedule following these explanatory notes.

OB. APPROVAL OF DENTAL PRACTITIONERS (ORAL AND MAXILLOFACIAL SURGEONS)

OB.1 Definition of Oral and Maxillofacial Surgery

Oral and Maxillofacial Surgery is defined as the surgical specialty which deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the oral and maxillofacial region.

OB.2 Application for Approval

State registered dentists practising in the specialty of oral and maxillofacial surgery may apply to the Medical Benefits (Dental Practitioners) Advisory Committee for the purposes of Subsection 3(1) of the Act for approval to carry out prescribed medical services (oral and maxillofacial surgery).

The Medical Benefits (Dental Practitioners) Advisory Committee considers applications lodged by dental practitioners and recommends to the Minister the names of those dental practitioners who, in its opinion, should be approved by the Minister for the purposes of Subsection 3(1) of the Act. Such dental practitioners must be State registered oral and maxillofacial surgeons in the State in which he/she is practising. In making its recommendations, the Committee may take into account a practitioner's training and experience in the field of oral and maxillofacial surgery and other factors which it may consider relevant. The Committee is comprised of dental practitioners nominated by the Australian Dental Association and appointed by the Minister.

When practitioners are approved to carry out prescribed medical services (oral and maxillofacial surgery) they may perform those items of oral and maxillofacial surgery listed in this category. All dental practitioners approved for the purposes of subsection 3(1) of the Act are also recognised to perform those items of oral and maxillofacial surgery listed in Group C2 of the booklet "Medicare Benefits for Treatment of Cleft Lip and Cleft Palate Conditions".

Practitioners who wish to be considered for approval for the purposes of Subsection 3(1) of the Act should write to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT, 2901 for an application form. Any enquiries may be directed to the Health Insurance Commission on (02) 6124 6753.

It is emphasised that -

- (i) the sole purpose of granting approval to dental practitioners is to enable payment of Medicare benefits;
- (ii) the services set out in Groups 01 to 011 of the Medicare Benefits Schedule book, and in the Cleft Lip and Cleft Palate Schedule are the only ones for which Medicare benefits are payable when the services are performed by an eligible dental practitioner.

OB.3 Right of Appeal for Dental Practitioners Not Approved

Where the Minister decides that a dental practitioner should not be approved as an oral and maxillofacial surgeon, the dental practitioner may appeal to the Medical Benefits (Dental Practitioners) Appeals Committee, which is composed of dental practitioners who are not on the Advisory Committee. The application should be made to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT, 2901.

EXPLANATORY NOTES

OC. INTERPRETATION OF THE SCHEDULE

OC.1 Principles of Interpretation

Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

OC.2 Multiple Operation Rule

The Schedule fees for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

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

- NOTE:
1. Fees so calculated which result in a sum which is not a multiple of 5 cents are to be taken to the next higher multiple of 5 cents
 2. Where two or more operations performed on the one occasion have fees which are equal, one of these amounts shall be treated as being greater than the other or others of those amounts.
 3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes all services in Groups [O3](#) to [O9](#).

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

OC.3 After-care (Post-operative Treatment)

The fee specified for each of the operations listed in the Schedule contains a component for the consequential after-care customarily provided unless otherwise indicated. After-care is deemed to include all post-operative treatment rendered by practitioners and need not necessarily be limited to treatment given by the approved dental practitioner or to treatment given by any one practitioner. This does not preclude, however, the payment of benefit for professional services for the treatment by a dental practitioner of an intercurrent condition or an unusual complication arising from the operation.

Some minor operations are merely stages in the treatment of a particular condition. Professional services by dental practitioners subsequent to such operations should not be regarded as after-care but rather as continuation of the treatment of the original condition and should attract benefit. Item [52057](#) is a service to which this policy applies.

OC.4 Administration of Anaesthetics by Medical Practitioners

When a medical practitioner administers an anaesthetic in connection with a procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an approved dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

For a trial period of two years commencing 1 November 2001, the Relative Value Guide (RVG) for Anaesthesia has been introduced into the Medicare Benefits Schedule under a cost neutral framework, as the basis for calculating the Medicare benefits for anaesthesia services.

Prior to the introduction of the RVG on 1 November 2001, the Schedule fee for anaesthesia was established by reference to the anaesthesia base ("B") and average time ("T") units allocated to the associated procedure. For example:

51904	LIPECTOMY - wedge excision of skin or fat - 1 excision (Anaes. I7710 = 4B + 6T)
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These anaesthesia unit values listed against medical/surgical/diagnostic and Oral & Maxillofacial services in the 1 November 2000 Medicare Benefits Schedule, no longer apply. From 1 November 2001 the Schedule fee for anaesthesia is established using the RVG schedule at Category 3 - Group [T10](#).

Before the payment of benefits for the administration of anaesthesia, or for the services of an assistant anaesthetist, a number of details additional to those set out in paragraph [7.1](#) of the General Explanatory Notes of the 1 November 2000 Medicare Benefits Schedule are required on the anaesthetist's account:

The anaesthetist's account must show the name/s of the medical practitioner/s who performed the associated operation/s. Also, where the after hours emergency modifier applies to the anaesthesia service, the account must include the start time, the end time and the total time of the anaesthesia;

The assistant anaesthetist's account must show the name/s of the medical practitioners who performed the associated operation/s, as well as the name of the principle anaesthetist. In addition, where the after hours emergency modifier applies, the assistant anaesthetist's account must record the start time, the end time and the total time for which he or she was providing professional attention to the patient during the anaesthesia.

OC.5 Consultations (Items [51700](#), [51703](#))

The consultation item numbers ([51700](#) and [51703](#)) are to be used by approved dental practitioners in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg scale and clean, construction of dentures, restorative dentistry or dental extraction).

OC.6 Assistance at Operations (Items [51800](#), [51803](#))

Items covering operations which are eligible for benefits for assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery or surgical assistance have been identified by the inclusion of the word "Assist" in the item description. Medicare benefits are not payable for surgical assistance associated with procedures which have not been so identified.

The assistance must be rendered by a practitioner other than the surgeon, the anaesthetist or the assistant anaesthetist.

Where more than one practitioner provides assistance to an approved dental practitioner no additional benefits are payable. The assistance benefit is the same irrespective of the number of practitioners providing assistance.

Benefits payable under item [51800](#)

Medicare benefits are payable under Item [51800](#) for assistance rendered at the following procedures:

[51900](#), [51904](#), [52010](#), [52018](#), [52039](#), [52048](#), [52051](#), [52062](#), [52063](#), [52066](#), [52078](#), [52090](#), [52092](#), [52095](#), [52105](#), [52108](#), [52111](#), [52130](#), [52138](#), [52141](#), [52144](#), [52147](#), [52182](#), [52300](#), [52303](#), [52312](#), [52315](#), [52321](#), [52324](#), [52336](#), [52339](#), [52424](#), [52440](#), [52452](#), [52480](#), [52482](#), [52600](#), [52603](#), [52609](#), [52612](#), [52615](#), [52624](#), [52626](#), [52627](#), [52800](#), [52803](#), [52806](#), [52809](#), [52818](#), [52824](#), [52828](#), [52830](#), [53006](#), [53009](#), [53016](#), [53215](#), [53220](#), [53225](#), [53226](#), [53236](#), [53239](#), [53242](#), [53406](#), [53409](#), [53412](#), [53413](#), [53415](#), [53416](#), [53453](#), [53460](#).

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under item [51300](#).

Benefits payable under Item [51803](#)

[51906](#), [52054](#), [52094](#), [52114](#), [52117](#), [52120](#), [52122](#), [52123](#), [52126](#), [52129](#), [52131](#), [52148](#), [52158](#), [52184](#), [52186](#), [52306](#), [52330](#), [52333](#), [52337](#), [52342](#), [52345](#), [52348](#), [52351](#), [52354](#), [52357](#), [52360](#), [52363](#), [52366](#), [52369](#), [52372](#), [52375](#), [52378](#), [52379](#), [52380](#), [52382](#), [52430](#), [52442](#), [52444](#), [52446](#), [52456](#), [52484](#), [52618](#), [52621](#), [52812](#), [52815](#), [52821](#), [52832](#), [53015](#), [53017](#), [53019](#), [53209](#), [53212](#), [53218](#), [53221](#), [53224](#), [53227](#), [53230](#), [53233](#), [53414](#), [53418](#), [53419](#), [53422](#), [53423](#), [53424](#), [53425](#), [53427](#), [53429](#), [53455](#).

or at a combination of procedures (including those identified as payable under item [51800](#) above) for which the aggregate fee exceeds the amount specified in the item.

Where assistance with any of the above procedures is provided by a medical practitioner, benefits are payable under Item [51303](#).

Assistance at multiple operations

Where assistance is provided at two or more operations performed on a patient on the one occasion the multi operation formula is applied to all the operations to determine the surgical fee payable to each approved dental practitioner. The multi-operation formula is then applied to those items at which assistance was rendered and for which Medicare benefits for assistance is payable to determine the abated fee level for assistance. The abated fee is used to determine the appropriate Schedule item covering the surgical assistance (ie either Items [51800/51300](#) or [51803/51303](#)).

The derived fee applicable to Item [51803/51303](#) is calculated on the basis of one-fifth of the abated Schedule fee for the surgery.

OC.7 OPERATIONS (GROUPS [3](#) TO [9](#))

Repair of Wound (Item [51900](#))

Item [51900](#) covers debridement of "deep and extensively contaminated" wound. Benefits are not payable under this item for debridement which would be expected to be encountered as part of an operative approach to the treatment of fractures.

Lipectomy, Wedge Excision - Two or More Excisions (Item [51906](#))

Multiple lipectomies attract benefits under Item [51906](#) once only, i.e. the multiple operation rule does not apply. Medicare benefits are not payable in respect of liposuction.

Upper aerodigestive tract endoscopic procedures (Item [52035](#))

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 General Notes for Guidance).

Tumour, cyst, ulcer or scar (Items [52036](#) to [52054](#))

It is recognised that odontogenic keratocysts, although not neoplastic, often require the surgical management of benign tumours.

Aspiration of haematoma (Item [52056](#))

Aspiration of haematoma is indicated in clinical situations where incision may leave an unsightly scar or where access is difficult for conventional drainage.

Osteotomy of Jaw (Items [52342](#) - [52375](#))

The fee and benefit for these items include the various forms of internal or dental fixation, jaw immobilisation, the transposition of nerves and vessels and bone grafts taken from the same site. Bone grafts taken from a separate site, e.g. iliac crest, would attract additional benefit under Item [52318](#) or [52319](#) for the harvesting, plus item [52130](#) or [52131](#) for the grafting.

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

Genioplasty (Item [52378](#))

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

Fracture of Mandible or Maxilla (Items [53400](#) - [53439](#))

There are two maxillae in the skull and for the purpose of these items the mandible is regarded as comprising two bones. Hence a bilateral fracture of the mandible would be assessed as, say Item [53409](#) x 1½; two maxillae and one side of the mandible as Item [53406](#) x 1½ + [53409](#) x ¼.

Splinting in Item [53406](#) or [53409](#) refers to cap splints, arch bars, silver (cast metal) or acrylic splints.

OC.8 Diagnostic Procedures and Investigations (Group [10](#))

Skin sensitivity testing (Item [53600](#))

The allergens are local anaesthetics and the contents of anaesthetic capsules, acrylic and other polymers and metals.

OC.9 Regional or Field Nerve Blocks (Group [11](#))

Destruction of Nerve Branch by Neurolytic Agent ([53706](#))

T7.7.1 This item includes the use of botulinus toxin as a neurolytic agent.

GROUP 01 - CONSULTATIONS	
APPROVED DENTAL PRACTITIONER, REFERRED CONSULTATION - SURGERY, HOSPITAL OR RESIDENTIAL AGED CARE FACILITY	
(Professional attendance at consulting rooms, hospital or residential aged care facility by an approved dental practitioner in the practice of oral and maxillofacial surgery where the patient is referred to him or her)	
<i>(The referral must be from a registered dental practitioner or a medical practitioner)</i>	
51700	- INITIAL attendance in a single course of treatment Fee: \$69.35 Benefit: 75% = \$52.05 85% = \$58.95
51703	- Each attendance SUBSEQUENT to the first in a single course of treatment Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60
GROUP 02 - ASSISTANCE AT OPERATION	
51800	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee does not exceed \$452.70 or at a series or combination of operations identified by the word "Assist." where the fee for the series or combination of operations identified by the word "Assist." does not exceed \$452.70 <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50
51803	Assistance by an approved dental practitioner in the practice of oral and maxillofacial surgery at any operation identified by the word "Assist." for which the fee exceeds \$452.70 or at a series or combination of operations identified by the word "Assist." where the aggregate fee exceeds \$452.70 <i>(See para OC, of explanatory notes to this Category)</i> Derived Fee: one fifth of the established fee for the operation or combination of operations
GROUP 03 - GENERAL SURGERY	
51900	WOUND OF SOFT TISSUE IN THE ORAL AND MAXILLOFACIAL REGION, deep or extensively contaminated, debridement of, under general anaesthesia or regional or field nerve block, including suturing of that wound when performed (Anaes.) (Assist.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70
51902	WOUNDS, OF THE ORAL AND MAXILLOFACIAL REGION, DRESSING OF, under general anaesthesia, with or without removal of sutures, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) Fee: \$59.90 Benefit: 75% = \$44.95 85% = \$50.95
51904	LIPECTOMY - in the oral and maxillofacial region - wedge excision of skin or fat - 1 EXCISION (Anaes.) (Assist.) Fee: \$368.80 Benefit: 75% = \$276.60 85% = \$313.50
51906	LIPECTOMY - in the oral and maxillofacial region - wedge excision of skin or fat - 2 OR MORE EXCISIONS (Anaes.) (Assist.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$560.95 Benefit: 75% = \$420.75 85% = \$503.85
52000	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), superficial (Anaes.) Fee: \$66.90 Benefit: 75% = \$50.20 85% = \$56.90
52003	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, small (NOT MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) Fee: \$95.25 Benefit: 75% = \$71.45 85% = \$81.00
52006	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), superficial (Anaes.) Fee: \$95.25 Benefit: 75% = \$71.45 85% = \$81.00
52009	SKIN AND SUBCUTANEOUS TISSUE OR MUCOUS MEMBRANE, REPAIR OF RECENT WOUND OF, on face or neck, large (MORE THAN 7 CM LONG), involving deeper tissue (Anaes.) Fee: \$150.55 Benefit: 75% = \$112.95 85% = \$128.00

52010	FULL THICKNESS LACERATION OF EAR, EYELID, NOSE OR LIP, repair of, with accurate apposition of each layer of tissue (Anaes.) (Assist.) Fee: \$205.90 Benefit: 75% = \$154.45 85% = \$175.05
52012	SUPERFICIAL FOREIGN BODY, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.) Fee: \$19.00 Benefit: 75% = \$14.25 85% = \$16.15
52015	SUBCUTANEOUS FOREIGN BODY, in the oral and maxillofacial region, removal of, requiring incision and suture, as an independent procedure (Anaes.) Fee: \$89.10 Benefit: 75% = \$66.85 85% = \$75.75
52018	FOREIGN BODY IN MUSCLE, TENDON OR OTHER DEEP TISSUE, in the oral and maxillofacial region, removal of, as an independent procedure (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70
52021	ASPIRATION BIOPSY of 1 or MORE JAW CYSTS as an independent procedure to obtain material for diagnostic purposes and not being a service associated with an operative procedure on the same day (Anaes.) Fee: \$23.90 Benefit: 75% = \$17.95 85% = \$20.35
52024	BIOPSY OF SKIN OR MUCOUS MEMBRANE, in the oral and maxillofacial region, as an independent procedure (Anaes.) Fee: \$42.35 Benefit: 75% = \$31.80 85% = \$36.00
52025	LYMPH NODE OF NECK, biopsy of (Anaes.) Fee: \$149.10 Benefit: 75% = \$111.85 85% = \$126.75
52027	BIOPSY OF LYMPH GLAND, MUSCLE OR OTHER DEEP TISSUE OR ORGAN, in the oral and maxillofacial region, as an independent procedure and not being a service to which item 52025 applies (Anaes.) Fee: \$121.40 Benefit: 75% = \$91.05 85% = \$103.20
52030	SINUS, in the oral and maxillofacial region, excision of, involving superficial tissue only (Anaes.) Fee: \$72.95 Benefit: 75% = \$54.75 85% = \$62.05
52033	SINUS, in the oral and maxillofacial region, excision of, involving muscle and deep tissue (Anaes.) Fee: \$149.10 Benefit: 75% = \$111.85 85% = \$126.75
52034	PREMALIGNANT LESIONS of the oral mucous, treatment by <u>cryotherapy, diathermy or carbon dioxide laser</u> Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60
52035	ENDOSCOPIC LASER THERAPY for neoplasia and benign vascular lesions of the oral cavity (Anaes.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$386.00 Benefit: 75% = \$289.50 85% = \$328.90
52036	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, not being a service to which item 52039 applies (Anaes.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$102.95 Benefit: 75% = \$77.25 85% = \$87.55
52039	TUMOURS, CYSTS, ULCERS OR SCARS, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, up to 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane, where the removal is by surgical excision and suture, and the procedure is performed on more than 3 but not more than 10 lesions (Anaes.) (Assist.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$264.30 Benefit: 75% = \$198.25 85% = \$224.70
52042	TUMOUR, CYST, ULCER OR SCAR, (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, more than 3 cm in diameter, removal from cutaneous or subcutaneous tissue or from mucous membrane (Anaes.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$139.85 Benefit: 75% = \$104.90 85% = \$118.90
52045	TUMOUR, CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), in the oral and maxillofacial region, removal of, not being a service to which another item in Groups O3 to O9 applies, involving muscle, bone, or other deep tissue (Anaes.) <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$199.80 Benefit: 75% = \$149.85 85% = \$169.85

52048	TUMOUR OR DEEP CYST (other than a cyst associated with a tooth or tooth fragment unless it has been established by radiological examination that there is a minimum of 5mm separation between the cyst lining and tooth structure or where a tumour or cyst has been proven by positive histopathology), in the oral and maxillofacial region, removal of, requiring wide excision, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$301.20 Benefit: 75% = \$225.90 85% = \$256.05
52051	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, without skin or mucosal graft (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$407.25 Benefit: 75% = \$305.45 85% = \$350.15
52054	TUMOUR, in the oral and maxillofacial region, removal of, from soft tissue (including muscle, fascia and connective tissue), extensive excision of, with skin or mucosal graft (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$476.45 Benefit: 75% = \$357.35 85% = \$419.35
52055	HAEMATOMA, SMALL ABSCESS OR CELLULITIS IN THE ORAL AND MAXILLOFACIAL REGION, not requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding after care) Fee: \$22.15 Benefit: 75% = \$16.65 85% = \$18.85
52056	HAEMATOMA IN THE ORAL AND MAXILLOFACIAL REGION, aspiration of (Anaes.) (See para OC , of explanatory notes to this Category) Fee: \$22.15 Benefit: 75% = \$16.65 85% = \$18.85
52057	LARGE HAEMATOMA, LARGE ABSCESS, CARBUNCLE, CELLULITIS or similar lesion IN THE ORAL AND MAXILLOFACIAL REGION, requiring admission to a hospital or day-hospital facility, INCISION WITH DRAINAGE OF (excluding aftercare) (Anaes.) Fee: \$132.15 Benefit: 75% = \$99.15 85% = \$112.35
52058	PERCUTANEOUS DRAINAGE OF DEEP ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION, using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$192.65 Benefit: 75% = \$144.50 85% = \$163.80
52059	ABSCESS IN THE ORAL AND MAXILLOFACIAL REGION DRAINAGE TUBE, exchange of using interventional imaging techniques - but not including imaging (Anaes.) Fee: \$217.00 Benefit: 75% = \$162.75 85% = \$184.45
52060	MUSCLE IN THE ORAL AND MAXILLOFACIAL REGION, excision of (Anaes.) Fee: \$153.55 Benefit: 75% = \$115.20 85% = \$130.55
52061	MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (limited), not associated with external wound (Anaes.) Fee: \$181.30 Benefit: 75% = \$136.00 85% = \$154.15
52062	MUSCLE, IN THE ORAL AND MAXILLOFACIAL REGION, RUPTURED, repair of (extensive), not associated with external wound (Anaes.) (Assist.) Fee: \$239.75 Benefit: 75% = \$179.85 85% = \$203.80
52063	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, INNOCENT, excision of, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) Fee: \$288.95 Benefit: 75% = \$216.75 85% = \$245.65
52064	BONE CYST IN THE ORAL AND MAXILLOFACIAL REGION, injection into or aspiration of (Anaes.) Fee: \$137.40 Benefit: 75% = \$103.05 85% = \$116.80
52066	SUBMANDIBULAR GLAND, extirpation of (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00
52069	SUBLINGUAL GLAND, extirpation of (Anaes.) Fee: \$161.00 Benefit: 75% = \$120.75 85% = \$136.85
52072	SALIVARY GLAND, DILATATION OR DIATHERMY of duct (Anaes.) Fee: \$47.65 Benefit: 75% = \$35.75 85% = \$40.55
52073	SALIVARY GLAND, repair of CUTANEOUS FISTULA OF (Anaes.) Fee: \$121.40 Benefit: 75% = \$91.05 85% = \$103.20

52117	MANDIBLE, including lower border, or MAXILLA, sub-total resection of (Anaes.) (Assist.) Fee: \$567.10 Benefit: 75% = \$425.35 85% = \$510.00
52120	MANDIBLE, hemimandiblectomy of, including condylectomy where performed (Anaes.) (Assist.) Fee: \$668.50 Benefit: 75% = \$501.40 85% = \$611.40
52122	MANDIBLE, hemi-mandibular reconstruction of, OR MAXILLA, reconstruction of, with BONE GRAFT, PLATE, TRAY OR ALLOPLAST, not being a service associated with a service to which item 52123 applies (Anaes.) (Assist.) Fee: \$670.70 Benefit: 75% = \$503.05 85% = \$613.60
52123	MANDIBLE, total resection of both sides, including condylectomies where performed (Anaes.) (Assist.) Fee: \$759.35 Benefit: 75% = \$569.55 85% = \$702.25
52126	MAXILLA, total resection of (Anaes.) (Assist.) Fee: \$730.05 Benefit: 75% = \$547.55 85% = \$672.95
52129	MAXILLA, total resection of both maxillae (Anaes.) (Assist.) Fee: \$977.25 Benefit: 75% = \$732.95 85% = \$920.15
52130	BONE GRAFT IN THE ORAL AND MAXILLOFACIAL REGION, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) Fee: \$358.75 Benefit: 75% = \$269.10 85% = \$304.95
52131	BONE GRAFT WITH INTERNAL FIXATION, IN THE ORAL AND MAXILLOFACIAL REGION, not being a service to which another item in Groups O3 to O9 applies (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05
52132	TRACHEOSTOMY (Anaes.) Fee: \$193.65 Benefit: 75% = \$145.25 85% = \$164.65
52133	CRICOTHYROSTOMY by direct stab or Seldinger technique, using Minitrache or similar device (Anaes.) Fee: \$73.80 Benefit: 75% = \$55.35 85% = \$62.75
52135	POST-OPERATIVE or POST-NASAL HAEMORRHAGE, or both, control of, where undertaken in the operating theatre of a hospital or approved day-hospital facility (Anaes.) Fee: \$117.05 Benefit: 75% = \$87.80 85% = \$99.50
52138	MAXILLARY ARTERY, ligation of (Anaes.) (Assist.) Fee: \$361.15 Benefit: 75% = \$270.90 85% = \$307.00
52141	FACIAL, MANDIBULAR or LINGUAL ARTERY or VEIN or ARTERY and VEIN, ligation of, not being a service to which item 52138 applies (Anaes.) (Assist.) Fee: \$359.70 Benefit: 75% = \$269.80 85% = \$305.75
52144	FOREIGN BODY, in the oral and maxillofacial region, deep, removal of using interventional imaging techniques (Anaes.) (Assist.) Fee: \$335.30 Benefit: 75% = \$251.50 85% = \$285.05
52147	DUCT OF MAJOR SALIVARY GLAND, transposition of (Anaes.) (Assist.) Fee: \$316.40 Benefit: 75% = \$237.30 85% = \$268.95
52148	PAROTID DUCT, repair of, using micro-surgical techniques (Anaes.) (Assist.) Fee: \$559.25 Benefit: 75% = \$419.45 85% = \$502.15
52158	SUBMANDIBULAR DUCTS, relocation of, for surgical control of drooling (Anaes.) (Assist.) Fee: \$900.50 Benefit: 75% = \$675.40 85% = \$843.40
MALIGNANT DISEASE	
52180	AGGRESSIVE OR POTENTIALLY MALIGNANT BONE OR DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, biopsy of (not including aftercare) (Anaes.) Fee: \$152.65 Benefit: 75% = \$114.50 85% = \$129.80
52182	BONE OR MALIGNANT DEEP SOFT TISSUE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of (Anaes.) (Assist.) Fee: \$335.85 Benefit: 75% = \$251.90 85% = \$285.50

52184	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of, combined with any 1 of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$496.15 Benefit: 75% = \$372.15 85% = \$439.05
52186	BONE TUMOUR IN THE ORAL AND MAXILLOFACIAL REGION, lesional or marginal excision of, combined with any 2 or more of: liquid nitrogen freezing, autograft, allograft or cementation (Anaes.) (Assist.) Fee: \$610.70 Benefit: 75% = \$458.05 85% = \$553.60
GROUP O4 - PLASTIC & RECONSTRUCTIVE	
52300	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, with skin or mucosa (Anaes.) (Assist.) Fee: \$230.55 Benefit: 75% = \$172.95 85% = \$196.00
52303	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, with buccal pad of fat (Anaes.) (Assist.) Fee: \$329.15 Benefit: 75% = \$246.90 85% = \$279.80
52306	SINGLE-STAGE LOCAL FLAP, in the oral and maxillofacial region, where indicated, repair to 1 defect, using temporalis muscle (Anaes.) (Assist.) Fee: \$488.50 Benefit: 75% = \$366.40 85% = \$431.40
52309	FREE GRAFTING (mucosa or split skin) of a granulating area in the oral and maxillofacial region, (Anaes.) Fee: \$166.00 Benefit: 75% = \$124.50 85% = \$141.10
52312	FREE GRAFTING (mucosa, split skin or connective tissue) to 1 defect in the oral and maxillofacial region, including elective dissection (Anaes.) (Assist.) Fee: \$230.55 Benefit: 75% = \$172.95 85% = \$196.00
52315	FREE GRAFTING, FULL THICKNESS, to 1 defect (mucosa or skin) in the oral and maxillofacial region (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05
52318	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - small quantity (Anaes.) Fee: \$114.55 Benefit: 75% = \$85.95 85% = \$97.40
52319	BONE GRAFT, harvesting of, via separate incision, being a service associated with a service to which another item in Groups O3 to O9 applies - Autogenous - large quantity (Anaes.) Fee: \$190.60 Benefit: 75% = \$142.95 85% = \$162.05
52321	FOREIGN IMPLANT (NON-BIOLOGICAL), insertion of in the oral and maxillofacial region, for CONTOUR RECONSTRUCTION of pathological deformity, not being a service associated with a service to which item 52624 applies (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05
52324	DIRECT FLAP REPAIR, using tongue, first stage (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05
52327	DIRECT FLAP REPAIR, using tongue, second stage (Anaes.) Fee: \$190.60 Benefit: 75% = \$142.95 85% = \$162.05
52330	PALATAL DEFECT (oro-nasal fistula), plastic closure of, including services to which item 52300 , 52303 , 52306 or 52324 applies (Anaes.) (Assist.) Fee: \$634.00 Benefit: 75% = \$475.50 85% = \$576.90
52333	CLEFT PALATE, primary repair (Anaes.) (Assist.) Fee: \$634.00 Benefit: 75% = \$475.50 85% = \$576.90
52336	CLEFT PALATE, secondary repair, closure of fistula using local flaps (Anaes.) (Assist.) Fee: \$396.25 Benefit: 75% = \$297.20 85% = \$339.15
52337	ALVEOLAR CLEFT (congenital) unilateral, grafting of, including plastic closure of associated oro-nasal fistulae and ridge augmentation (Anaes.) (Assist.) Fee: \$866.80 Benefit: 75% = \$650.10 85% = \$809.70
52339	CLEFT PALATE, secondary repair, lengthening procedure (Anaes.) (Assist.) Fee: \$451.30 Benefit: 75% = \$338.50 85% = \$394.20

52342	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$783.85 Benefit: 75% = \$587.90 85% = \$726.75
52345	MANDIBLE or MAXILLA, unilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90
52348	MANDIBLE or MAXILLA, bilateral osteotomy or osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$998.95 Benefit: 75% = \$749.25 85% = \$941.85
52351	MANDIBLE or MAXILLA, bilateral osteotomy of osteectomy of, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,121.80 Benefit: 75% = \$841.35 85% = \$1,064.70
52354	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,137.25 Benefit: 75% = \$852.95 85% = \$1,080.15
52357	MANDIBLE or MAXILLA, osteotomies or osteectomies of, involving 3 or more such procedures on the 1 jaw, including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,280.40 Benefit: 75% = \$960.30 85% = \$1,223.30
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.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,306.20 Benefit: 75% = \$979.65 85% = \$1,249.10
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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,469.40 Benefit: 75% = \$1,102.05 85% = \$1,412.30
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.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,436.95 Benefit: 75% = \$1,077.75 85% = \$1,379.85
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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,615.60 Benefit: 75% = \$1,211.70 85% = \$1,558.50
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.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,567.65 Benefit: 75% = \$1,175.75 85% = \$1,510.55
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 stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$1,755.95 Benefit: 75% = \$1,317.00 85% = \$1,698.85

52378	GENIOPLASTY including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) (See para OC . of explanatory notes to this Category) Fee: \$607.00 Benefit: 75% = \$455.25 85% = \$549.90
52379	FACE, contour reconstruction of 1 region, using autogenous bone or cartilage graft (Anaes.) (Assist.) Fee: \$1,036.45 Benefit: 75% = \$777.35 85% = \$979.35
52380	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site (Anaes.) (Assist.) Fee: \$1,766.45 Benefit: 75% = \$1,324.85 85% = \$1,709.35
52382	MIDFACIAL OSTEOTOMIES - Le Fort II, Modified Le Fort III (Nasomalar), Modified Le Fort III (Malar-Maxillary), Le Fort III involving 3 or more osteotomies of the midface including transposition of nerves and vessels and bone grafts taken from the same site and stabilisation with fixation by wires, screws, plates or pins, or any combination (Anaes.) (Assist.) Fee: \$2,117.40 Benefit: 75% = \$1,588.05 85% = \$2,060.30
52420	MANDIBLE, fixation by intermaxillary wiring, excluding wiring for obesity Fee: \$195.50 Benefit: 75% = \$146.65 85% = \$166.20
52424	DERMIS, DERMOFAT OR FASCIA GRAFT (excluding transfer of fat by injection) IN THE ORAL AND MAXILLOFACIAL REGION (Anaes.) (Assist.) Fee: \$384.05 Benefit: 75% = \$288.05 85% = \$326.95
52430	MICROVASCULAR REPAIR OF THE ORAL AND MAXILLOFACIAL REGION using microsurgical techniques, with restoration of continuity of artery or vein of distal extremity or digit (Anaes.) (Assist.) Fee: \$884.00 Benefit: 75% = \$663.00 85% = \$826.90
52440	CLEFT LIP, unilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$438.95 Benefit: 75% = \$329.25 85% = \$381.85
52442	CLEFT LIP, unilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$548.80 Benefit: 75% = \$411.60 85% = \$491.70
52444	CLEFT LIP, bilateral - primary repair, 1 stage, without anterior palate repair (Anaes.) (Assist.) Fee: \$609.65 Benefit: 75% = \$457.25 85% = \$552.55
52446	CLEFT LIP, bilateral - primary repair, 1 stage, with anterior palate repair (Anaes.) (Assist.) Fee: \$719.50 Benefit: 75% = \$539.65 85% = \$662.40
52450	CLEFT LIP, partial revision, including minor flap revision alignment and adjustment, including revision of minor whistle deformity if performed (Anaes.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30
52452	CLEFT LIP, total revision, including major flap revision, muscle reconstruction and revision of major whistle deformity (Anaes.) (Assist.) Fee: \$396.25 Benefit: 75% = \$297.20 85% = \$339.15
52456	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), first stage (Anaes.) (Assist.) Fee: \$670.70 Benefit: 75% = \$503.05 85% = \$613.60
52458	CLEFT LIP RECONSTRUCTION using full thickness flap (Abbe or similar), second stage (Anaes.) Fee: \$243.85 Benefit: 75% = \$182.90 85% = \$207.30
52460	VELO-PHARYNGEAL INCOMPETENCE, pharyngeal flap for, or pharyngoplasty for (Anaes.) Fee: \$634.00 Benefit: 75% = \$475.50 85% = \$576.90
52480	COMPOSITE GRAFT (Chondro-cutaneous or chondro-mucosal) to nose, ear or eyelid (Anaes.) (Assist.) Fee: \$407.25 Benefit: 75% = \$305.45 85% = \$350.15
52482	MACROCHEILIA or macroglossia, operation for (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70
52484	MACROSTOMIA, operation for (Anaes.) (Assist.) Fee: \$466.45 Benefit: 75% = \$349.85 85% = \$409.35

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
GROUP 05 - PREPROSTHETIC			
52600	MANDIBULAR OR PALATAL EXOSTOSIS, excision of (Anaes.) (Assist.) Fee: \$274.30	Benefit: 75% = \$205.75	85% = \$233.20
52603	MYLOHYOID RIDGE, reduction of (Anaes.) (Assist.) Fee: \$262.20	Benefit: 75% = \$196.65	85% = \$222.90
52606	MAXILLARY TUBEROSITY, reduction of (Anaes.) Fee: \$200.00	Benefit: 75% = \$150.00	85% = \$170.00
52609	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - less than 5 lesions (Anaes.) (Assist.) Fee: \$262.20	Benefit: 75% = \$196.65	85% = \$222.90
52612	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - 5 to 20 lesions (Anaes.) (Assist.) Fee: \$329.15	Benefit: 75% = \$246.90	85% = \$279.80
52615	PAPILLARY HYPERPLASIA OF THE PALATE, removal of - more than 20 lesions (Anaes.) (Assist.) Fee: \$408.55	Benefit: 75% = \$306.45	85% = \$351.45
52618	VESTIBULOPLASTY, submucosal or open, including excision of muscle and skin or mucosal graft when performed - unilateral or bilateral (Anaes.) (Assist.) Fee: \$475.45	Benefit: 75% = \$356.60	85% = \$418.35
52621	FLOOR OF MOUTH LOWERING (Obwegeser or similar procedure), including excision of muscle and skin or mucosal graft when performed - unilateral (Anaes.) (Assist.) Fee: \$475.45	Benefit: 75% = \$356.60	85% = \$418.35
52624	ALVEOLAR RIDGE AUGMENTATION with bone or alloplast or both - unilateral (Anaes.) (Assist.) Fee: \$384.05	Benefit: 75% = \$288.05	85% = \$326.95
52626	ALVEOLAR RIDGE AUGMENTATION - unilateral, insertion of tissue expanding device into maxillary or mandibular alveolar ridge region for (Anaes.) (Assist.) Fee: \$235.50	Benefit: 75% = \$176.65	85% = \$200.20
52627	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, extra oral implantation of titanium fixture (Anaes.) (Assist.) Fee: \$408.55	Benefit: 75% = \$306.45	85% = \$351.45
52630	OSSEO-INTEGRATION PROCEDURE - in the practice of oral and maxillofacial surgery, fixation of transcutaneous abutment (Anaes.) Fee: \$151.20	Benefit: 75% = \$113.40	85% = \$128.55
52633	OSSEO-INTEGRATION PROCEDURE - intra-oral implantation of titanium fixture to facilitate restoration of the dentition following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) Fee: \$408.55	Benefit: 75% = \$306.45	85% = \$351.45
52636	OSSEO-INTEGRATION PROCEDURE - fixation of transmucosal abutment to fixtures placed following resection of part of the maxilla or mandible for benign or malignant tumours (Anaes.) Fee: \$151.20	Benefit: 75% = \$113.40	85% = \$128.55

ORAL & MAXILLOFACIAL	ORAL & MAXILLOFACIAL
GROUP O6 - NEUROSURGICAL	
52800	NEUROLYSIS BY OPEN OPERATION, in the oral and maxillofacial region, without transposition, not being a service associated with a service to which item 52803 applies (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70
52803	NERVE TRUNK, internal (interfascicular), in the oral and maxillofacial region, NEUROLYSIS of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$323.10 Benefit: 75% = \$242.35 85% = \$274.65
52806	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from superficial peripheral nerve in the oral and maxillofacial region (Anaes.) (Assist.) Fee: \$224.35 Benefit: 75% = \$168.30 85% = \$190.70
52809	NEURECTOMY, NEUROTOMY or REMOVAL OF TUMOUR from deep peripheral nerve in the oral and maxillofacial region (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05
52812	NERVE TRUNK, in the oral and maxillofacial region, PRIMARY repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$548.80 Benefit: 75% = \$411.60 85% = \$491.70
52815	NERVE TRUNK, in the oral and maxillofacial region, SECONDARY repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$579.15 Benefit: 75% = \$434.40 85% = \$522.05
52818	NERVE, in the oral and maxillofacial region, TRANSPOSITION OF (Anaes.) (Assist.) Fee: \$384.15 Benefit: 75% = \$288.15 85% = \$327.05
52821	NERVE GRAFT TO NERVE TRUNK in the oral and maxillofacial region (cable graft) including harvesting of nerve graft using microsurgical techniques (Anaes.) (Assist.) Fee: \$835.20 Benefit: 75% = \$626.40 85% = \$778.10
52824	PERIPHERAL BRANCHES OF THE TRIGEMINAL NERVE, cryosurgery of, for pain relief (Anaes.) (Assist.) Fee: \$359.70 Benefit: 75% = \$269.80 85% = \$305.75
52826	INJECTION OF PRIMARY BRANCH OF TRIGEMINAL NERVE with alcohol, cortisone, phenol, or similar substance (Anaes.) Fee: \$192.65 Benefit: 75% = \$144.50 85% = \$163.80
52828	CUTANEOUS NERVE, in the oral and maxillofacial region, primary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$286.55 Benefit: 75% = \$214.95 85% = \$243.60
52830	CUTANEOUS NERVE, in the oral and maxillofacial region, secondary repair of, using microsurgical techniques (Anaes.) (Assist.) Fee: \$377.90 Benefit: 75% = \$283.45 85% = \$321.25
52832	CUTANEOUS NERVE, in the oral and maxillofacial region, nerve graft to, using microsurgical techniques (Anaes.) (Assist.) Fee: \$518.25 Benefit: 75% = \$388.70 85% = \$461.15

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
GROUP O7 - EAR, NOSE & THROAT			
53000	MAXILLARY ANTRUM, PROOF PUNCTURE AND LAVAGE OF (Anaes.) Fee: \$26.35	Benefit: 75% = \$19.80	85% = \$22.40
53003	MAXILLARY ANTRUM, proof puncture and lavage of, under general anaesthesia (requiring admission to hospital) not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) Fee: \$74.60	Benefit: 75% = \$55.95	85% = \$63.45
53004	MAXILLARY ANTRUM, LAVAGE OF - each attendance at which the procedure is performed, including any associated consultation (Anaes.) Fee: \$27.20	Benefit: 75% = \$20.40	85% = \$23.15
53006	ANTROSTOMY (RADICAL) (Anaes.) (Assist.) Fee: \$422.60	Benefit: 75% = \$316.95	85% = \$365.50
53009	ANTRUM, intranasal operation on, or removal of foreign body from (Anaes.) (Assist.) Fee: \$239.75	Benefit: 75% = \$179.85	85% = \$203.80
53012	ANTRUM, drainage of, through tooth socket (Anaes.) Fee: \$95.25	Benefit: 75% = \$71.45	85% = \$81.00
53015	ORO-ANTRAL FISTULA, plastic closure of (Anaes.) (Assist.) Fee: \$476.45	Benefit: 75% = \$357.35	85% = \$419.35
53016	NASAL SEPTUM, septoplasty, submucous resection or closure of septal perforation (Anaes.) (Assist.) Fee: \$391.80	Benefit: 75% = \$293.85	85% = \$334.70
53017	NASAL SEPTUM, reconstruction of (Anaes.) (Assist.) Fee: \$488.85	Benefit: 75% = \$366.65	85% = \$431.75
53019	MAXILLARY SINUS, BONE GRAFT to floor of maxillary sinus following elevation of mucosal lining (sinus lift procedure), (unilateral) (Anaes.) (Assist.) Fee: \$470.95	Benefit: 75% = \$353.25	85% = \$413.85
53052	POST-NASAL SPACE, direct examination of, with or without biopsy (Anaes.) Fee: \$99.55	Benefit: 75% = \$74.70	85% = \$84.65
53054	NASENDOSCOPY or SINOSCOPY or FIBREOPTIC EXAMINATION of NASOPHARYNX one or more of these procedures (Anaes.) Fee: \$99.50	Benefit: 75% = \$74.65	85% = \$84.60
53056	EXAMINATION OF NASAL CAVITY or POST-NASAL SPACE, or NASAL CAVITY AND POST-NASAL SPACE, UNDER GENERAL ANAESTHESIA, not being a service associated with a service to which another item in this Group applies (Anaes.) Fee: \$58.35	Benefit: 75% = \$43.80	85% = \$49.60
53058	NASAL HAEMORRHAGE, POSTERIOR, ARREST OF, with posterior nasal packing with or without cauterisation and with or without anterior pack (excluding aftercare) (Anaes.) Fee: \$99.50	Benefit: 75% = \$74.65	85% = \$84.60
53060	CAUTERISATION (other than by chemical means) OR CAUTERISATION by chemical means when performed under general anaesthesia OR DIATHERMY OF SEPTUM, TURBINATES FOR OBSTRUCTION OR HAEMORRHAGE SECONDARY TO SURGERY (OR TRAUMA) - 1 or more of these procedures (including any consultation on the same occasion) not being a service associated with any other operation on the nose (Anaes.) Fee: \$81.45	Benefit: 75% = \$61.10	85% = \$69.25
53062	POST SURGICAL NASAL HAEMORRHAGE, arrest of during an episode of epistaxis by cauterisation or nasal cavity packing or both (Anaes.) Fee: \$72.95	Benefit: 75% = \$54.75	85% = \$62.05
53064	CRYOTHERAPY TO NOSE in the treatment of nasal haemorrhage (Anaes.) Fee: \$132.15	Benefit: 75% = \$99.15	85% = \$112.35
53068	TURBINECTOMY or TURBINECTOMIES, partial or total, unilateral (Anaes.) Fee: \$109.35	Benefit: 75% = \$82.05	85% = \$92.95

ORAL & MAXILLOFACIAL		ORAL & MAXILLOFACIAL	
53070	TURBINATES, submucous resection of, unilateral (Anaes.) Fee: \$144.35 Benefit: 75% = \$108.30 85% = \$122.70		
GROUP O8 - TEMPOROMANDIBULAR JOINT			
53200	MANDIBLE, treatment of a dislocation of, not requiring open reduction (Anaes.) Fee: \$57.30 Benefit: 75% = \$43.00 85% = \$48.75		
53203	MANDIBLE, treatment of a dislocation of, requiring open reduction (Anaes.) Fee: \$96.35 Benefit: 75% = \$72.30 85% = \$81.90		
53206	TEMPOROMANDIBULAR JOINT, manipulation of, performed in the operating theatre of a hospital or approved day-hospital facility, not being a service associated with a service to which another item in Groups O3 to O9 applies (Anaes.) Fee: \$115.85 Benefit: 75% = \$86.90 85% = \$98.50		
53209	GLENOID FOSSA, ZYGOMATIC ARCH and TEMPORAL BONE, reconstruction of (Obwegeser technique) (Anaes.) (Assist.) Fee: \$1,337.00 Benefit: 75% = \$1,002.75 85% = \$1,279.90		
53212	ABSENT CONDYLE and ASCENDING RAMUS in hemifacial microsomia, construction of, not including harvesting of graft material (Anaes.) (Assist.) Fee: \$722.30 Benefit: 75% = \$541.75 85% = \$665.20		
53215	TEMPOROMANDIBULAR JOINT, arthroscopy of, with or without biopsy, not being a service associated with any other arthroscopic procedure of that joint (Anaes.) (Assist.) Fee: \$331.30 Benefit: 75% = \$248.50 85% = \$281.65		
53218	TEMPOROMANDIBULAR JOINT, arthroscopy of, removal of loose bodies, debridement, or treatment of adhesions - 1 or more such procedures (Anaes.) (Assist.) Fee: \$530.05 Benefit: 75% = \$397.55 85% = \$472.95		
53220	TEMPOROMANDIBULAR JOINT, arthrotomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$267.20 Benefit: 75% = \$200.40 85% = \$227.15		
53221	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$707.25 Benefit: 75% = \$530.45 85% = \$650.15		
53224	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with condylectomy or condylotomy, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$784.00 Benefit: 75% = \$588.00 85% = \$726.90		
53225	ARTHROCENTESIS, irrigation of temporomandibular joint after insertion of 2 cannuli into the appropriate joint space(s) (Anaes.) (Assist.) Fee: \$235.50 Benefit: 75% = \$176.65 85% = \$200.20		
53226	TEMPOROMANDIBULAR JOINT, synovectomy of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$253.20 Benefit: 75% = \$189.90 85% = \$215.25		
53227	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with or without meniscus or capsular surgery, including meniscectomy when performed, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$963.35 Benefit: 75% = \$722.55 85% = \$906.25		
53230	TEMPOROMANDIBULAR JOINT, open surgical exploration of, with meniscus, capsular and condylar head surgery, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$1,085.20 Benefit: 75% = \$813.90 85% = \$1,028.10		
53233	TEMPOROMANDIBULAR JOINT, surgery of, involving procedures to which items 53224 , 53226 , 53227 and 53230 apply and also involving the use of tissue flaps, or cartilage graft, or allograft implants, with or without microsurgical techniques (Anaes.) (Assist.) Fee: \$1,219.40 Benefit: 75% = \$914.55 85% = \$1,162.30		
53236	TEMPOROMANDIBULAR JOINT, stabilisation of, involving 1 or more of: repair of capsule, repair of ligament or internal fixation, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50		

53239	TEMPOROMANDIBULAR JOINT, arthrodesis of, not being a service to which another item in this Group applies (Anaes.) (Assist.) Fee: \$381.60 Benefit: 75% = \$286.20 85% = \$324.50
53242	TEMPOROMANDIBULAR JOINT OR JOINTS, application of external fixator to, other than for treatment of fractures (Anaes.) (Assist.) Fee: \$253.20 Benefit: 75% = \$189.90 85% = \$215.25
GROUP 09 - TREATMENT OF FRACTURES	
53400	MAXILLA, unilateral or bilateral, treatment of fracture of, not requiring splinting (See para OC , of explanatory notes to this Category) Fee: \$104.75 Benefit: 75% = \$78.60 85% = \$89.05
53403	MANDIBLE, treatment of fracture of, not requiring splinting (See para OC , of explanatory notes to this Category) Fee: \$127.95 Benefit: 75% = \$96.00 85% = \$108.80
53406	MAXILLA, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$329.70 Benefit: 75% = \$247.30 85% = \$280.25
53409	MANDIBLE, treatment of fracture of, requiring splinting, wiring of teeth, circumosseous fixation or external fixation (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$329.70 Benefit: 75% = \$247.30 85% = \$280.25
53410	ZYGOMATIC BONE, treatment of fracture of, not requiring surgical reduction (See para OC , of explanatory notes to this Category) Fee: \$69.45 Benefit: 75% = \$52.10 85% = \$59.05
53411	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction by a temporal, intra-oral or other approach (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$193.65 Benefit: 75% = \$145.25 85% = \$164.65
53412	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation at 1 site (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$317.90 Benefit: 75% = \$238.45 85% = \$270.25
53413	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 2 sites (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$388.50 Benefit: 75% = \$291.40 85% = \$331.40
53414	ZYGOMATIC BONE, treatment of fracture of, requiring surgical reduction and involving internal or external fixation or both at 3 sites (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$447.35 Benefit: 75% = \$335.55 85% = \$390.25
53415	MAXILLA, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$353.25 Benefit: 75% = \$264.95 85% = \$300.30
53416	MANDIBLE, treatment of fracture of, requiring open reduction (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$353.25 Benefit: 75% = \$264.95 85% = \$300.30
53418	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$459.15 Benefit: 75% = \$344.40 85% = \$402.05
53419	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation not involving plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$459.15 Benefit: 75% = \$344.40 85% = \$402.05

53422	MAXILLA, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$582.75 Benefit: 75% = \$437.10 85% = \$525.65
53423	MANDIBLE, treatment of fracture of, requiring open reduction and internal fixation involving plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$582.75 Benefit: 75% = \$437.10 85% = \$525.65
53424	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$500.00 Benefit: 75% = \$375.00 85% = \$442.90
53425	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction not involving plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$500.00 Benefit: 75% = \$375.00 85% = \$442.90
53427	MAXILLA, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$682.90 Benefit: 75% = \$512.20 85% = \$625.80
53429	MANDIBLE, treatment of a complicated fracture of, involving viscera, blood vessels or nerves, requiring open reduction involving the use of plate(s) (Anaes.) (Assist.) (See para OC , of explanatory notes to this Category) Fee: \$682.90 Benefit: 75% = \$512.20 85% = \$625.80
53439	MANDIBLE, treatment of a closed fracture of, involving a joint surface (Anaes.) (See para OC , of explanatory notes to this Category) Fee: \$193.65 Benefit: 75% = \$145.25 85% = \$164.65
53453	ORBITAL CAVITY, reconstruction of a wall or floor with or without foreign implant (Anaes.) (Assist.) Fee: \$391.80 Benefit: 75% = \$293.85 85% = \$334.70
53455	ORBITAL CAVITY, bone or cartilage graft to orbital wall or floor including reduction of prolapsed or entrapped orbital contents (Anaes.) (Assist.) Fee: \$460.25 Benefit: 75% = \$345.20 85% = \$403.15
53458	NASAL BONES, treatment of fracture of, not being a service to which item 53459 or 53460 applies Fee: \$34.85 Benefit: 75% = \$26.15 85% = \$29.65
53459	NASAL BONES, treatment of fracture of, by reduction (Anaes.) Fee: \$190.90 Benefit: 75% = \$143.20 85% = \$162.30
53460	NASAL BONES, treatment of fractures of, by open reduction involving osteotomies (Anaes.) (Assist.) Fee: \$389.40 Benefit: 75% = \$292.05 85% = \$332.30
GROUP O10 - DIAGNOSTIC PROCEDURES AND INVESTIGATIONS	
53600	SKIN SENSITIVITY TESTING for allergens to anaesthetics and materials used in OMS surgery, USING 1 TO 20 ALLERGENS (See para OC , of explanatory notes to this Category) Fee: \$31.55 Benefit: 75% = \$23.70 85% = \$26.85

GROUP O11 - REGIONAL OR FIELD NERVE BLOCKS	
	(Note. Where an anaesthetic combines a regional nerve block with a general anaesthetic for an operative procedure, benefits will be paid only under the anaesthetic item relevant to the operation. The items in this Group are to be used in the practice of oral and maxillofacial surgery and are not to be used for dental procedures (eg. restorative dentistry or dental extraction.))
53700	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent Fee: \$101.20 Benefit: 75% = \$75.90 85% = \$86.05
53702	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent Fee: \$50.70 Benefit: 75% = \$38.05 85% = \$43.10
53704	FACIAL NERVE, injection of an anaesthetic agent Fee: \$30.50 Benefit: 75% = \$22.90 85% = \$25.95
53706	NERVE BRANCH IN THE ORAL AND MAXILLOFACIAL REGION, destruction by a neurolytic agent, not being a service to which any other item in this Group applies <i>(See para OC, of explanatory notes to this Category)</i> Fee: \$101.20 Benefit: 75% = \$75.90 85% = \$86.05



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DIAGNOSTIC IMAGING SERVICES

CATEGORY 5

PLEASE NOTE:

The information contained in this Category relates specifically to the Diagnostic Imaging Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.



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CATEGORY 5 - DIAGNOSTIC IMAGING SERVICES

DIA OUTLINE OF ARRANGEMENTS

DIA.1 DIAGNOSTIC IMAGING SERVICES TABLE

The *Health Insurance Act 1973* allows the Minister for Health and Ageing to determine an appropriate Diagnostic Imaging Services Table which is then prescribed by Regulation.

The Diagnostic Imaging Agreement commenced in 1998 as part of an agreement with the Royal Australian and New Zealand College of Radiologists (RANZCR). The Agreement was originally for 3 years and extended a further two years in 2000 and the Australian Diagnostic Imaging Association (ADIA) became party to the Agreement.

Overall management of the Diagnostic Imaging Agreement and consequent amendments to the Diagnostic Imaging Services Table (DIST) is through the Diagnostic Imaging Management Committee (DIMC). DIMC consists of representatives from the RANZCR, ADIA, HIC and the Commonwealth Department of Health and Ageing (DoHA).

Further supporting the work of the DIMC are other advisory groups and project teams. The following groups are consulted regularly in relation to proposed changes to the DIST:

- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANCOG)
- National Association of Specialist Obstetricians and Gynaecologists (NASOG)
- Royal Australian and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM)
- Australian College of Rural and Remote Medicine (ACCRM)
- Royal Australian College of General Practitioners (RACGP)
- Cardiac Society of Australia and New Zealand (CSANZ)
- Ultrasound Association (USA)
- Australian Rheumatology Association (ARA)
- Australian College of Sports Physicians (ACSP)
- Australian Sonographers Association (ASA)
- Australian Orthopaedic Association (AOA)
- Australasian Musculoskeletal Imaging Group (AMSIG)

DIA.2 SERVICES RENDERED "ON BEHALF" OF MEDICAL PRACTITIONERS

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

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

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

DIA.3 BASIC REQUIREMENTS FOR MEDICARE ELIGIBILITY

DIA.3.1 *General rule for eligibility*

Except in circumstances detailed in [DIA.5](#), a Medicare benefit is not payable for a diagnostic imaging service unless:

prior to commencing the relevant service, the providing practitioner receives a signed and dated written request from a requesting practitioner (the treating practitioner) who determined that the service was necessary.

A valid written request can be made by a medical practitioner, on behalf of the requesting practitioner, for example, by a resident medical officer at a hospital on behalf of the patient's practitioner.

The requesting practitioner may also be:

for X-rays of the head and certain other services - a dental practitioner, periodontist, endodontist, pedodontist, orthodontist, prosthodontist, oral medicine surgeon, oral pathology surgeon, or oral and maxillofacial surgeon.
for X-rays of the spine and pelvic region - a chiropractor or a physiotherapist; and
for specified X-rays of the foot the requesting practitioner may also be a podiatrist (see [DIA.4.7](#))

The requesting practitioner must turn his or her mind to the clinical relevance of the request and determine that the service is necessary for the adequate professional care of the patient.

Items of service which are subject to the written request requirement are classified as “R type” (requested services) and the items of service not subject to the written request requirement are classified as “NR-type” (not requested) services. For further details refer to “Explanatory Notes to the Diagnostic Imaging Services Table”.

DIA.3.2 *Professional Supervision*

Ultrasound (R-type), Computed Tomography and Magnetic Resonance Imaging services are not eligible for a Medicare rebate unless the service is performed under the professional supervision of the providing practitioner- refer to the relevant sections in the Notes for further details.

DIA.3.3 *Referral to Specified Practitioner Not Required*

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

DIA.3.4 *Request for More Than One Service and Limit on Time to Render Services*

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

DIA.4 EXEMPTIONS FROM BASIC REQUIREMENTS FOR MEDICARE ELIGIBILITY

There are exemptions from the general written request requirements (R-type). These are detailed below.

DIA.4.1 *Consultant Physician or Specialist*

Except for R-type items which preclude in their description (such as most R-type items in General Ultrasound and items [59300](#), [59303](#)) an exemption from the written request provisions, **a written request is not required (“NR-type”) for the payment of Medicare benefits when:**

The diagnostic imaging service is provided by or on behalf of a consultant physician or a specialist (other than a specialist in diagnostic radiology) in his or her specialty and after clinical assessment he/she determines that the service was necessary. See section [DIB.1.3](#) for details required on accounts.

However, if in the referral to the consultant physician or a specialist, the referring practitioner specifically requests a diagnostic imaging service (eg to a cardiologist to perform an echocardiogram) the service provided is a requested, not self-determined service. If further services are subsequently provided, these further services are self-determined - see [DIA.4.5](#) “Additional Necessary Services”.

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.

DIA.4.2 *Remote Area Exemption*

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

the "R-type" service is not one for which there is a corresponding "NR-type" service; and
the medical practitioner rendering the service has been granted a remote area exemption for that service.

Further information regarding the remote area exemption is set out in section DIC. See section [DIB.1.3](#) for details required on accounts.

DIA.4.3 *Emergencies*

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

DIA.4.4 *Lost Requests*

The written request requirement does not apply where:

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

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

In respect of requests by dentists, chiropractors, physiotherapists or podiatrists, the lost request exemption is applicable only to radiographic examinations of the specific areas they can request. For details required on accounts, see section [DIB.1.3](#).

DIA.4.5 *Additional Necessary Services*

Except for R-type items which preclude in their description (such as most R-type items in General Ultrasound and items [59300](#), [59303](#)) an exemption from the written request provisions, a written request is not required for a diagnostic imaging service if that service was rendered after one which had been formally requested and the providing practitioner had determined that, on the basis of the results obtained from the requested service, that an additional service was necessary. For details required on accounts, see section [DIB.1.3](#).

DIA.4.6 *Pre-existing Diagnostic Imaging Practices*

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

- a) be treating his or her own patient;
- b) have determined that the service was necessary;
- c) have rendered between 17 October 1988 and 16 October 1990 at least 50 services (which resulted in the payment of Medicare benefits) of the kind which have been designated "R-type" services from 1 May 1991;
- d) provide the exempted services at the practice location where the services which enabled the practitioner to qualify for the "grandparent" exemption were rendered; and
- e) be enrolled in an approved continuing medical education and quality assurance program from 1 January 2001. For further information, please contact the Royal Australian College of General Practitioners (RACGP) or Australian College of Rural and Remote Medicine (ACRRM).

Benefits are only payable for services exempted under these provisions where the service was rendered by the exempted medical practitioner at the exempted location. Exemptions are not transferable.

The above exemption applies to the services covered by the following Items: [57712](#), [57715](#), [57901](#), [57902](#), [57903](#), [57912](#), [57915](#), [57921](#), [58100](#), [58103](#), [58106](#), [58108](#), [58109](#), [58112](#), [58115](#), [58521](#), [58524](#), [58527](#), [58700](#), [58924](#) and [59103](#).

For details required on accounts, see section [DIB.1.3](#).

DIA.4.7 *Diagnostic Imaging Services Requested by Dental Practitioners, Dental Specialists, Chiropractors, Physiotherapists and Podiatrists*

The legislation specifies (R) type diagnostic imaging services which may be requested by dental practitioners, chiropractors, physiotherapists and podiatrists, subject to the requirements of State and Territory laws.

Dental practitioners may request the following items:

[57509](#), [57515](#), [57521](#), [57527](#), [57901](#), [57902](#), [57903](#), [57906](#), [57909](#), [57912](#), [57915](#), [57918](#), [57921](#), [57924](#), [57927](#), [57930](#), [57933](#), [57939](#), [57942](#), [57945](#), [57960](#), [57963](#), [57966](#), [57969](#), [58100](#), [58300](#), [58503](#), [58903](#), [59733](#), [59739](#), [59751](#), [60100](#), [60500](#), [60503](#).

From 1 November 2001, new item numbers, [57948](#), [57951](#), [57954](#) and [57957](#) were introduced to replace item number 57936. However, in light of continuing concerns regarding the relevance of the item descriptors, and after consultation with dental practitioners, item descriptors 57948, 57951, 57954 and 57957 have been deleted and replaced with item numbers [57960](#), [57963](#), [57966](#) and [57969](#) effective from 1 November 2002.

In addition to the above items, **Dental specialists** (periodontists, endodontists, pedodontists, orthodontists, prosthodontists, oral and maxillofacial surgeons and specialists in oral medicine and oral pathology) may request the following items:

[56022](#), [56062](#), [58306](#), [61421](#), [61454](#), [61457](#), [63621](#), [63671](#), [63712](#).

Prosthodontists may also request the following items:

[55028](#), [56013](#), [56016](#), [56028](#), [56053](#), [56056](#), [56068](#), [61425](#), [61429](#), [61430](#), [61433](#), [61434](#), [61446](#), [61449](#), [61450](#), [61453](#), [61462](#).

Oral and maxillofacial surgeons may also request the following items:

[55028](#), [55030](#), [55032](#), [56001](#), [56007](#), [56010](#), [56013](#), [56016](#), [56022](#), [56028](#), [56030](#), [56036](#), [56041](#), [56047](#), [56050](#), [56053](#), [56056](#), [56062](#), [56068](#), [56070](#), [56076](#), [56101](#), [56107](#), [56141](#), [56147](#), [56219](#), [56220](#), [56224](#), [56227](#), [56230](#), [56259](#), [56301](#), [56307](#), [56341](#), [56347](#), [56401](#), [56407](#), [56409](#), [56412](#), [56441](#), [56447](#), [56449](#), [56452](#), [56501](#), [56507](#), [56541](#), [56547](#), [56801](#), [56807](#), [56841](#), [56847](#), [57001](#), [57007](#), [57041](#), [57047](#), [57341](#), [57345](#), [57703](#), [57709](#), [57712](#), [57715](#), [58103](#), [58106](#), [58108](#), [58109](#), [58112](#), [58115](#), [58306](#), [58506](#), [58521](#), [58524](#), [58527](#), [58909](#), [59103](#), [59703](#), [60000](#), [60003](#), [60006](#), [60009](#), [60506](#), [60509](#), [61109](#), [61372](#), [61421](#), [61425](#), [61429](#), [61430](#), [61433](#), [61434](#), [61446](#), [61449](#), [61450](#), [61453](#), [61454](#), [61457](#), [61462](#), [63621](#), [63671](#), [63712](#).

Specialists in oral medicine and/or oral pathology may also request the following items:

[55028](#), [55030](#), [55032](#), [56001](#), [56007](#), [56010](#), [56013](#), [56016](#), [56022](#), [56028](#), [56041](#), [56047](#), [56050](#), [56053](#), [56056](#), [56062](#), [56068](#), [56101](#), [56107](#), [56141](#), [56147](#), [56301](#), [56307](#), [56341](#), [56347](#), [56401](#), [56407](#), [56441](#), [56447](#), [57341](#), [57345](#), [58306](#), [58506](#), [58909](#), [59103](#), [59703](#), [60000](#), [60003](#), [60006](#), [60009](#), [60506](#), [60509](#), [61109](#), [61372](#), [61421](#), [61425](#), [61429](#), [61430](#), [61433](#), [61434](#), [61446](#), [61449](#), [61450](#), [61453](#), [61454](#), [61457](#), [63003](#), [63103](#), [63273](#), [63621](#), [63671](#), [63712](#).

Chiropractors and physiotherapists may request the following items:

[57712](#), [57715](#), [58100](#), [58103](#), [58106](#), [58108](#), [58109](#), [58112](#), [58115](#).

Podiatrists may request the following items:

[57521](#), [57527](#).

DIA.5 MEDICARE BENEFITS NOT PAYABLE

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

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

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

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

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

The Managing Director of HIC may notify the relevant State or Territory authorities if he/she believes that a person may have contravened a law of a State or Territory relating directly or indirectly to the use of diagnostic imaging procedures or equipment.

DIA.6 MULTIPLE SERVICES RULES

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

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

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

- the diagnostic imaging service with the highest Schedule fee has an unchanged Schedule fee; and
- the Schedule fee for each additional diagnostic imaging service is reduced by \$5.

Rule B. When an R-type diagnostic imaging service and a consultation are rendered for a patient by the same practitioner on the one day, there is a deduction to the Schedule fee for the diagnostic imaging service with the highest Schedule fee. The amount of the deduction will vary depending on the level of the Schedule fee for the consultation. The deductions are as follows:

When the Schedule fee for the consultation is \$40 or more:

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

When the Schedule fee for the consultation is less than \$40:

- the Schedule fee for the diagnostic imaging service with the highest Schedule fee is reduced by \$15.

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

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

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

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

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

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

- Category 2, items [11000](#) to [12533](#);
- Category 3, items [13020](#) to [51312](#);
- Category 4, items [51700](#) to [53460](#);
- Cleft Lip and Palate services, items [75001](#) to [75854](#).

Pathology services are not included in Rule C.

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

For application of these rules to multiple vascular ultrasound services - refer to [DIF.6](#)

DIA.7 DIAGNOSTIC IMAGING SERVICES WITH AN ANAESTHESIA COMPONENT

New arrangements for the payment of Medicare benefits for anaesthetic services were introduced with effect from 1 November 2001. These effectively remove the anaesthetic formula. In addition, a new schedule of anaesthetic items has been introduced onto the General Medical Services Table.

These new arrangements have impacted on the Diagnostic Imaging Services Table as follows:

Payment of Medicare benefits for anaesthesia are restricted to instances where the anaesthetic has been performed in association with an 'eligible service'; ie, a service which is identified in the item description by the term 'Anaes.'

Where a service has previously been identified as attracting an anaesthetic, the anaesthesia formula has been removed from item descriptions and the term 'Anaes.' has been retained or inserted into the item description.

Additional items have been identified as being eligible for an anaesthesia service, and have had the term 'Anaes.' inserted into the item description. These include all other CT, MRI, digital subtraction angiography and selective coronary arteriography items not previously identified.

DIB. DIAGNOSTIC IMAGING SERVICES REQUESTS

DIB.1 Form etc. of Request

DIB.1.1 Details of Services Requested

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

A written request must also be signed and dated and contain the name and address or name and provider number in respect of the place of practice of the requesting practitioner.

DIB.1.2 Contravention of Request Requirements

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

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

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

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

If the professional service is provided by a specialist in diagnostic radiology the name and either the practice address or provider number for the practice address where the service was provided of the radiologist who provided the service.

If the medical practitioner is not a specialist in diagnostic radiology the name and either the practice address or provider number of the practitioner who is claiming or receiving fees.

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

Accounts for services that are self-determined, that is, not provided following a specific request from another practitioner, must be endorsed with the letters "SD" to indicate that the service was self-determined. Services are classified as self determined when rendered:

- by a consultant physician or specialist, in the course of that consultant physician or specialist practising his or her speciality (other than a specialist in diagnostic radiology), or
- in a remote area, or
- as an additional service, or
- under a pre-existing diagnostic imaging practice exemption.

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

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

Location Specific Practice Numbers

From 1 May 2003, providers of diagnostic imaging services will need to include a Location Specific Practice Number on accounts, receipts and Medicare assignment of benefits forms. This number will be used to indicate the practice site (or mobile service) at which a diagnostic imaging procedure is undertaken as part of a diagnostic imaging service. For more details about Location Specific Practice Numbers, including details of how to register a practice site, please contact the Department on (02) 6289 8852, or visit www.diagnosticimaging.health.gov.au or email diagnosticimaging@health.gov.au.

DIB.1.4 *Retention of R-type Requests etc.*

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

A medical practitioner must, if requested by the Managing Director, HIC, produce written requests retained by that practitioner for an "R-type" diagnostic imaging service as soon as practicable or by the end of the day after the day on which the Managing Director's request was made.

The officer of HIC is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations of lost requests.

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

DIB.1.5 *Other Records of Diagnostic Imaging Services*

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

These records must include the report by the providing practitioner on the diagnostic imaging service. For ultrasound services, where the service is performed on behalf of a medical practitioner the report must record the name of the sonographer.

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

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

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

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

Officers of the HIC may make and retain copies, or take and retain extracts, of such records.

A medical practitioner who, without reasonable excuse, contravenes any of the above provisions is guilty of an offence under the Health Insurance Act 1973 punishable, upon conviction, by a fine of \$1000.

DIC. REMOTE AREA EXEMPTIONS

DIC.1 Application for Remote Area Exemption

A medical practitioner, being a general practitioner (GP) or other medical practitioner, who believes that he or she qualifies for exemption under the remote area definition, should obtain an application form from HIC's website www.hic.gov.au or by contacting HIC, Provider Liaison Section, on 132150 for the cost of a local call.

For remote area exemption purposes only, the definition of a remote area is one:

- (a) that is more than 30 kilometres by road from a hospital which provides a radiology service under the direction of a specialist in the specialty of diagnostic radiology; and
- (b) that is more than 30 kilometres by road from a free-standing radiology facility under the direction of a specialist in the specialty of diagnostic radiology.

As is explained in DIC.1.3, a remote area exemption may be restricted to certain services.

DIC.1.1 *Quality Assurance Requirement*

Application for, or continuation of, the exemption will be contingent on practitioners being enrolled in an approved continuing medical education and quality assurance program. For further information, please contact the Australian College of Rural and Remote Medicine (ACRRM) on (07) 3352 8600

DIC.1.2 *Grant of Remote Area Exemption*

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

- (a) the applicant provided the required information;
- (b) the applicant's practice is located in a remote area; and
- (c) the facilities for rendering "R-type" diagnostic imaging services in the area in which the applicant's practice is located, including any visiting facilities, are such that, were the formal written request requirement to apply to the rendering of those services, patients in the area would suffer physical or financial hardship.

DIC.1.3 *Restrictions on Remote Area Exemption*

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

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

DIC.1.4 *Refusal of Application*

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

DIC.1.5 *Deemed Refusal for Review Purposes*

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

DIC.1.6 *Renewal of Exemption*

A holder of a remote area exemption may apply for its renewal at any time within six months before it is due to expire. In any event, HIC will send the holder a reminder notice and a renewal application six weeks before the current exemption expires. The arrangements for dealing with renewal applications are the same as those applying to initial applications.

DIC.1.7 *Revocation of Exemption*

The Minister may revoke a remote area exemption if satisfied that the practice of the practitioner granted the exemption is no longer situated in a remote area, or that adequate diagnostic imaging facilities have become available in the relevant area to enable the written request requirement to operate without causing physical or financial hardship to patients in that area.

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

Before revoking a remote area exemption, the practitioner will be given written notice:

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

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

DIC.1.8 *Review by Administrative Appeals Tribunal*

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

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

DIC.1.9 *Statements to Accompany Notification of Decisions*

When a person affected by a decision set out in DIC.1.8 is given written notice of that decision, the notice must include a statement advising that, if the person is dissatisfied with the decision, an application may be made to the Administrative Appeals Tribunal for a review of that decision.

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

DID. PROHIBITED PRACTICES

DID.1 Prohibited Diagnostic Imaging Practices

For Medicare benefit purposes, a person is taken to be engaged in a prohibited diagnostic practice if either directly or indirectly:

Service Provider: a)

- offer any inducement (whether by way of money, property or other benefit or advantage), or
- b) threatens any detriment or disadvantage, to a practitioner or any other person in order to encourage the practitioner to request the rendering of a diagnostic imaging service; or
- c) invites a practitioner to request the rendering of a diagnostic imaging service, or
- d) undertakes any act or thing that the person knows, or ought reasonably to know, is likely to have the effect of encouraging a practitioner to request the rendering of a diagnostic imaging service, or

Practitioner, or the employer of a practitioner: (a)

- without reasonable excuse, asks, receives or obtains, or agrees to receive or obtain, any property, benefit or advantage of any kind for himself or herself, or any other person, from a service provider or a person acting on behalf of the service provider; or
- b) accepts a request from another practitioner to render a diagnostic imaging service and in respect of any service (including a service for the use of diagnostic imaging equipment) connected with the rendering of the diagnostic imaging service, makes a payment, directly or indirectly to the other practitioner or if the diagnostic imaging service is not provided in a hospital - to a person who is the other practitioner's employer or to an employee of such a person; or
- c) accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:
 - (i) the two practitioners share, directly or indirectly, the cost of employing staff, or of buying, renting or maintaining items of equipment; and
 - (ii) the amounts payable under the arrangement are not fixed at normal commercial rates; or
- d) accepts a request from another practitioner to render a diagnostic imaging service where there is in force an arrangement under which:
 - (i) the 2 practitioners share a particular space in a building; or
 - (ii) one practitioner provides, directly or indirectly, space in a building for the use or occupation of the other practitioner or permits the other practitioner to use or occupy space in a building; and
 - (iii) the amounts payable under the arrangement are not fixed at normal commercial rates; or

Specialist:

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

DIE NOTICE OF POSSIBLE BREACHES

DIE.1 Notice Required

Where the Minister has reasonable grounds for believing that a person has engaged in prohibited diagnostic imaging practices, written notice will be given to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister within 28 days to show cause why no further action should be taken in this matter.

DIE.2 Decisions by the Minister

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

Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the person has engaged in a prohibited diagnostic imaging practice. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee.

DIF. ULTRASOUND

EXPLANATORY NOTES

Principles of Interpretation and Billing

- (1) *The service rendered must be clinically relevant for Medicare benefits to be payable. A "clinically relevant" service is a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered.*

As an example, an ultrasound to determine the sex of a foetus is not a clinically relevant service (unless there is an indication that the sex of the foetus will determine further courses of treatment, eg., a genetic background to a sex-related disease or condition).

- (2) *A service may only be billed for Medicare benefit purposes where the service rendered complies with the description in the relevant item.*

Where a service is covered specifically by an item, another item which also covers the service in more general terms, cannot be used.

Examples are:-

(a) Ultrasound of the prostate, bladder base and urethra are covered by Items 55600 and 55603. A Medicare benefit is only payable for examination of these organs when the service fulfils the conditions set out in these item descriptions. Items covering examination of the urinary tract - Items 55038 and 55039, or male pelvis - Items 55044 and 55045, cannot be used instead of 55600 and 55603 for an ultrasound examination of the prostate, bladder base and urethra alone.

(b) For some items, benefits are not payable unless there is a written request and the referring practitioner is not a member of the group of practitioners of which the rendering practitioner is also a member.

This requirement relates specifically to R-type ultrasound services of body regions in:

General Ultrasound

(Items [55028](#), [55030](#), [55032](#), [55036](#), [55038](#), [55044](#), [55048](#), [55070](#), [55076](#)):

Obstetric and Gynaecological Ultrasound

([55700](#), [55704](#), [55706](#), [55712](#), [55718](#), [55721](#), [55725](#), [55728](#), [55731](#), [55736](#), [55759](#), [55764](#), [55768](#), [55772](#)); and

Musculoskeletal Ultrasound

([55800](#), [55804](#), [55808](#), [55812](#), [55816](#), [55820](#), [55824](#), [55828](#), [55832](#), [55836](#), [55840](#), [55844](#), [55848](#), [55850](#)).

Services under the above items cannot be "self-determined" by a radiologist, by any other specialist or consultant physician or by any other medical practitioner. However, a medical practitioner may bill for the "NR-type" where he or she determines that the service is clinically relevant for the treatment of the patient's condition.

DIF.1 Professional Supervision for Ultrasound Services - R-type eligible services

Ultrasound services marked with the symbol (R) with the exception of items [55600](#) and [55603](#) are not eligible for a Medicare rebate unless the diagnostic imaging procedure is performed:

- a) under the professional supervision of a specialist or a consultant physician in the practice of his or her specialty who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary to personally attend the patient; or
- b) under the professional supervision of a practitioner who is not a specialist or consultant physician who meets the requirements of (A) hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination and, if necessary, to personally attend the patient; or

- c) under the professional supervision of a practitioner who meets the requirements of (B) hereunder, and who is available to monitor and influence the conduct and diagnostic quality of the examination, and if necessary, to personally attend the patient; or
 - d) if paragraph (a), (b) or (c) cannot be complied with: (i) in an emergency; or (ii) in a location that is not less than 30 kilometres by the most direct road route from another practice where services that comply with subparagraph (a) or (b) are available.
- A. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner at the location where the service was rendered and the rendering of those services resulted in the payment of a Medicare benefit.
- B. Between 1 September 1997 and 31 August 1999, at least 50 services were rendered by or on behalf of the practitioner to a patient in a nursing home or at the patient's residence and the rendering of those services resulted in the payment of a Medicare benefit.

DIF.2 Benefits payable for ultrasound examinations

As a rule, benefit is payable once only for ultrasonic examination at the one *attendance*, irrespective of the areas involved.

Except as indicated in the succeeding paragraphs, *attendance* means that there is a clear separation between one service and the next. For example, from 1 November 1993, where there is a short time between one ultrasound and the next, benefits will be payable for one service only. As a guide, HIC will look to a separation of 3 hours between services and this must be stated on accounts issued for more than 1 service on the one day.

Where more than one ultrasound service is rendered on the one occasion and the additional service relates to a non-contiguous body area, and the services provided are "clinically relevant", that is, the service is generally accepted in the medical profession as being necessary for the appropriate treatment or management of the patient to whom it is rendered), benefits greater than the single rate may be payable. Accounts should be marked "non-contiguous body areas".

Benefits for two contiguous areas may be payable where it is generally accepted that there are different preparation requirements for the patient and a clear difference in set-up time and scanning. Accounts should be endorsed "contiguous body area with different set-up requirements".

DIF.3 Ultrasound NR and R-type requests

Items in the range [55028](#) to [55054](#), [55700](#) to [55774](#), and [55800](#) to [55850](#) identified with:

the symbol "(NR)" cover ultrasound where the examination is rendered by a practitioner on his/her patient and cannot be self determined by the treating practitioner.

the symbol "(R)" cover the examination where the patient has been referred to a medical practitioner outside the referring practitioner's practice specifically for the ultrasound scanning.

DIF.4 Rules for musculoskeletal ultrasound

DIF.4.1 *Single rebate per day*

Ultrasound of one or more musculoskeletal areas ([55800](#) to [55854](#)) is payable only once irrespective of the number of regions scanned.

DIF.4.2 *Comparison musculoskeletal ultrasound*

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

DIF.4.3 *Equipment*

Items [55800](#) to [55854](#) only apply to an ultrasound service performed using an ultrasound system which has available on-site a transducer capable of operation at, at least, 7.5 megahertz.

DIF.4.4 *Personal attendance for Musculoskeletal Ultrasound*

Medicare Benefits are only payable for a musculoskeletal ultrasound service (items [55800](#) to [55854](#)) performed by or on behalf of a medical practitioner where the medical practitioner responsible for the conduct and report of the examination personally attends during the provision of the scan and personally examines the patient.

Services that are performed because of medical necessity in a remote location are exempt from this requirement - refer section DIC.1 for definition of remote area

DIF.5 *Routine Ultrasonic Scanning*

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

Details of diagnostic imaging requesting requirement are set out in the Explanatory Notes to the Diagnostic Imaging Services Table.

DIF.6 *Investigations of Vascular Disease (Items [55238-55296](#))*

Multiple Vascular Ultrasound Services Site Rule

Effective from 1 May 2002, a fee discount model was introduced to more appropriately remunerate multiple vascular ultrasound services under the MBS. The Multiple Vascular Ultrasound Services Site Rule (MVUSSR) encompasses the following:

- The deletion of specific multiple scan vascular ultrasound items and a revision of Schedule fee levels.
- Vascular ultrasound services must be performed by or on behalf of a medical practitioner.
- Medicare benefits will only be paid for two vascular ultrasound studies within the same working week. A study may include one or more items.
- For the calculation of the Medicare benefits payable for vascular ultrasound items performed on the same day the following formula will apply:

100% for the item with the greatest Schedule fee
plus 60% for the item with the next greatest Schedule fee
plus 50% for each other item.

Where multiple vascular ultrasound services are rendered in conjunction with another professional service, the multiple vascular ultrasound services are regarded as one service for the purposes of applying the Diagnostic Imaging Multiple Services Rules - refer [DIA.6](#).

Application of the MVUSSR - examples of clinical scenarios

Example 1:

When a patient is referred for a bilateral vascular service of both legs/both arms, the first service is rebated at 100% of the Schedule fee, the second is rebated at 60% of the Schedule fee.

Example 2:

When a patient is referred for two vascular services (eg carotid duplex and lower limb DVT) the first service is rebated at 100% of the Schedule fee, the second service is rebated at 60% of the Schedule fee.

Example 3:

When a patient is referred for a series of vascular services (eg carotid duplex, single lower limb DVT and upper limb arteries) the first service is rebated at 100% of the Schedule fee, the second service is rebated at 60% of the Schedule fee. Further services will be rebated at 50% of the Schedule fee.

Example 4:

When a patient is referred for venous and arterial services of the one region/limb, only a single item can be claimed for that one limb. The MVUSSR does not apply. The medical practitioner claiming Medicare benefit must indicate the side to be studied.

Note: the MVUSSR will apply to all vascular ultrasound items claimed on the same day of service ie whether performed at the same attendance or at different attendances.

Separation of services on the one day/contiguous and non-contiguous body areas

These rules do not apply to the vascular ultrasound items and therefore will not impact on the MVUSSR.

Items [11603](#), [11606](#), [11609](#) and [11612](#) - Examination of peripheral vessels

Vascular ultrasound services can continue to be claimed in conjunction with items [11603](#), [11606](#), [11609](#) and [11612](#).

DIF.7 Sonographer Accreditation

Sonographers performing medical ultrasound examinations (either R or NR type items) on behalf of a medical practitioner must be suitably qualified, involved in a relevant and appropriate Continuing Professional Development program and be Registered on the Register of Accredited Sonographers held by the Health Insurance Commission. For further information, please contact the Department on (02) 6289 7727 or the Australasian Sonographer Accreditation Registry on (02) 8850 1144 or through their website at <http://www.asar.com.au>

DIF.7.1 Eligibility for registration

In general, to be eligible for registration, the person must:

- hold an accredited postgraduate qualification in medical ultrasound;
- be studying ultrasound; or
- have worked as a sonographer under the direction of a medical practitioner in Australia or New Zealand (conditions apply*).

For assessment of eligibility status, please contact the Australasian Sonographer Accreditation Registry.

DIF.7.2 Reporting requirements

The sonographer's initial and surname is to be written on the report. The name of the sonographer is not required to be included on the copy of the report given to the patient.

For the purpose of this rule, the "name" means the sonographer's initial and surname.

DIF.8 Urological - Transrectal Ultrasound (Items [55600](#) and [55603](#))

Benefits for these items are attracted only where the service is rendered in the circumstances specified in both items. These provide that -

- a digital rectal examination was personally performed by the medical practitioner who also personally rendered the ultrasound service; and
- the equipment used meets specifications; and
- the patient was assessed prior to the service by a medical practitioner recognised in one or more of the specialties specified, not more than 60 days prior to the ultrasound service.

Item [55600](#) provides for the service where rendered by a medical practitioner who **did not** assess the patient, whereas Item [55603](#) provides for the service where rendered by a medical practitioner who **did** assess the patient.

DIF.9 Rules for Obstetric Ultrasound

DIF.9.1 NR Requests

Medicare benefits are not payable for more than 3 items of NR-type ultrasound services in Subgroup 5 of Group I1 (ultrasound) that are performed on the same patient in any 1 pregnancy.

DIF.9.2 *Clinical indications*

For items where clinical indications are listed, or where a clinical indication is required for performance of subsequent scans (items [55712](#), [55715](#), [55721](#), [55725](#), [55764](#), [55766](#), [55772](#), or [55774](#)) the referral must identify the relevant clinical indication for the service. It should be noted that a patient must have previously had either a [55706](#) or [55709](#) ultrasound in the same pregnancy to be eligible to claim for either a [55712](#) or [55715](#) obstetric service. To be eligible to claim for either a [55721](#) or [55725](#) obstetric service, a patient must have previously had either a [55718](#) or [55723](#) ultrasound in the same pregnancy.

If the service is self-determined, the clinical condition or indication must be recorded in the medical practitioner's clinical notes.

DIF.9.3 *Obstetric Ultrasound Items for Multiple Pregnancies*

As of 1 November 2000, obstetric ultrasound items [55759](#) to [55774](#) were introduced to cover scanning of a patient who is experiencing a multiple pregnancy.

The items incorporate a fee adjustment in recognition of the added complexity and costs associated with scanning multiple pregnancies. Based on the recommendations of the profession, the items apply only to patients where a multiple pregnancy has been confirmed by ultrasound.

The items include identical restrictions and provisions as the 2nd and 3rd trimester items ([55706-55725](#)), and include items for referred and non-referred services. The '(xix) multiple pregnancy' clinical indication that was included in items [55718](#) and [55723](#) has also been removed.

DIF.10 **Ultrasound Scan of Pelvis or Abdomen, pregnancy related - Item 55728**

This item should only be utilised in situations where a patient with a clinical condition not listed in items [55718](#), [55721](#), [55723](#) and [55725](#) requires a post 22 week ultrasound. Claims for this item are required to be assessed by the Health Insurance Commission on an individual basis and should be accompanied by details of the clinical basis for the service. The claim and the additional information should be lodged with Medicare, for referral to the National Office of the Commission, in a sealed envelope marked 'Medical-in Confidence'. (See note 8.7 of the General Explanatory Note.)

DIF.11 **Obstetric ultrasound and non-metropolitan providers (Items [55712](#), [55721](#) and [55728](#))**

In relation to items [55712](#), [55721](#) and [55728](#), non-metropolitan area includes any location outside of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin or Canberra major statistical divisions, as defined in the Australian Standard Geographical Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999).

DIF.12 **Referral forms from practitioners who have non-metropolitan obstetric privileges**

Where a practitioner who has obstetric privileges at a non-metropolitan hospital refers for items [55712](#), [55721](#) and [55728](#), [55764](#) and [55772](#), the practitioner must confirm his/her eligibility by stating 'non-metropolitan obstetric privileges' on the referral form.

DIG. COMPUTED TOMOGRAPHY (CT)

DIG.1 General

Pre-contrast scans are included in an item of service with contrast medium only when the pre-contrast scans are of the same region.

DIG.2 CT service where PET scan is performed

Medicare benefits are not payable for any CT scans rendered using a Hybrid PET/CT scanner.

DIG.3 CT Spine Items

CT items exist which separate the examination of the spine into the cervical, thoracic and lumbosacral regions. The new items are [56220](#) to [56240](#) inclusive. They include items for CT scans of two regions of the spine ([56233](#), [56234](#), [56235](#) and [56236](#)) and for all three regions of the spine ([56237](#), [56238](#), [56239](#) and [56240](#))

Restrictions apply to the following items:

- a) Item [56233](#) is used where two examinations from items [56220](#), [56221](#) and [56223](#) are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
- b) Item [56234](#) is used where two examinations from items [56224](#), [56225](#) and [56226](#) are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
- c) Item [56235](#) is used where two examinations from items [56227](#), [56228](#) and [56229](#) are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed
- d) Item [56236](#) is used where two examinations from items [56230](#), [56231](#) and [56232](#) are performed. The item numbers of the examination which are performed must be shown on any accounts issued or patient assignment forms completed

Example: for a CT examination of the spine where the cervical and thoracic regions are to be studied (item [56233](#)), item number [56221](#) must be specified.

DIG.4 Scan of more than one area

Items have been provided to cover the common combinations of regions - see section [DIG.7](#). However, where regions are scanned on the one occasion which are not covered by a combination item, for example, item [57001](#) (scan of brain) and item [56619](#) (scan of extremities), both examinations would attract separate benefit.

DIG.5 CT Scan of Spine with Intrathecal Contrast Medium (Item [56219](#))

The item incorporates the cost of contrast medium for intrathecal injection and associated x-rays. Benefits are not payable for this item when rendered in association with myelograms (Item [59724](#)).

Where a myelogram is rendered under item [59724](#) and a CT is necessary, the relevant item would be scan of spine without intravenous contrast (Item [56220](#), [56221](#) and [56223](#)).

DIG.6 CT Scans of Multiple Regions

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

DIG.7 More than one Attendance of the Patient to Complete a Scan

Item numbers [56219](#) to [56259](#) and [56619](#) to [56665](#) apply once only for a service described in any of those items, regardless of the number of patient attendances required to complete the service.

For example, where a request relates to two or more regions of the spine and one region only is scanned on one occasion with the balance of regions being scanned on a subsequent occasion, benefits are payable for one service only.

DIG.8 Professional Supervision of Computed Tomography (CT)

CT services are not eligible for a Medicare rebate unless the service is performed under the professional supervision of a specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and including, if necessary, personal attendance on the patient.

Services that are performed in an emergency, or because of medical necessity in a remote location, are exempt from this requirement - refer [DIC.1](#) for definition of remote area.

DIG.9 Capital Sensitive Items

A reduced Schedule fee applies to CT services provided on equipment that is 10 years old or older. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of items cover services provided on older equipment. These items are:

[56041](#), [56047](#), [56050](#), [56053](#), [56056](#), [56062](#), [56068](#), [56070](#), [56076](#), [56141](#), [56147](#), [56259](#), [56341](#), [56347](#), [56441](#), [56447](#), [56449](#), [56452](#), [56541](#), [56547](#), [56659](#), [56665](#), [56841](#), [56847](#), [57041](#), [57047](#), [57247](#), [57345](#), [57355](#).

These items are identified by the addition of the letter '(NK)' at the end of the item. These items should be used where services are performed on equipment ten years old or older, except where equipment is located in a remote area when items with the letter "K", as described below, will apply - refer section [DIC.1](#) for definition of remote area.

Existing items have been amended to add the letter '(K)' at the end of the item. These items should be used for services which are performed on a date which is less than ten years after the date on which the CT equipment used in performing the service was first installed in Australia. In the case of imported pre-used CT equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment.

For the purposes of capital sensitive items CT equipment includes the following components:

- (a) gantry;
- (b) couch;
- (c) computer; and
- (d) operator station.

DIG.10 Exclusion of Acoustic Neuroma

Where axial scans are undertaken for the exclusion of acoustic neuroma, Medicare benefits are payable under item [56001](#) or [56007](#).

DIG.11 Assessment of headache

If the service described in item [56007](#) or [56047](#) is to be used for the assessment of headache of a patient to whom this rule applies, the fee mentioned in the item applies only if:

- (a) a scan without intravenous contrast medium has been undertaken on the patient; and
- (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal.

This rule applies to a patient who a)

- is under 50 years; and
- b) is (apart from the headache) otherwise well; and
- c) has no localising symptoms or signs; and
- d) has no history of malignancy or immunosuppression.

DIH. DIAGNOSTIC RADIOLOGY

DIH.1 Examination and Report

The benefits allocated to each item from [57506](#) to [61109](#) inclusive covers the total procedure, ie. the examination, reading and report. Separate benefits are not payable for individual components of the service, eg preliminary reading.

Where preliminary plain films were frequently billed with a procedure item, the value of the plain film fee(s) have been incorporated into the new item fee and the descriptions amended to include words such as “including any preliminary plain films”. Benefits are not separately payable for associated plain films involved with these items.

DIH.2 Films - exposure of more than one

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

DIH.3 Comparison X-rays - Limbs

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

DIH.4 New Orthopantomography items

From 1 November 2001 four new items [57948](#), [57951](#), [57954](#) and [57957](#) were introduced into the MBS. It was since observed that the item descriptions remained too broad and a review was undertaken, in consultation with dental practitioner representation, to further refine the descriptions.

Effective from 1 November 2002, items [57948](#), [57951](#), [57954](#) and [57957](#) have been deleted and replaced with four new items and descriptions. The new items and descriptions are [57960](#), [57963](#), [57966](#) and [57969](#).

DIH.5 Spine Items

Multiple region items require that the regions of the spine to be studied must be specified on any account issued or patient assignment forms completed.

Where item [58112](#) is rendered (spine, two regions), the item numbers for the regions of the spine being studied must be specified (ie from items [58100](#), [58103](#), [58106](#) and [58109](#)).

Example: for a radiographic examination of the spine where the cervical and thoracic regions are to be studied, item numbers [58100](#) and [58103](#) must be specified on any account issued or patient assignment forms completed.

Where item [58115](#) is rendered (spine, three regions), the item numbers for the regions of the spine being studied must be specified (items [58100](#), [58103](#), [58106](#) and [58109](#)).

Example: for a radiographic examination of the spine where the cervical, the thoracic and the lumbosacral regions are to be studied, item numbers [58100](#), [58103](#) and [58106](#) must be specified on any accounts issued or patient assignment forms completed.

DIH.6 Plain Abdominal Film (Item [58900/58903](#))

Benefits are not attracted for Items [58900/58903](#) in association with barium meal examinations or cholecystograms whether provided on the same day or previous day. Preliminary plain films are covered in each study.

DIH.7 Mammography - Professional Supervision

Mammography services are not eligible for a Medicare rebate unless the service is performed under the professional supervision of a specialist in the specialty of diagnostic radiology who is available to monitor and influence the conduct and diagnostic quality of the examination, and including, if necessary, personal attendance on the patient.

Services that are performed in an emergency, or because of medical necessity in a remote location, are exempt from this requirement - refer section [DIC.1](#) for definition of remote area.

DIH.8 Radiography of the Breast

Benefits under items [59300](#) and [59303](#) are attracted only where the patient has been referred in specific circumstances as indicated in the description of the items. To facilitate these provisions, the Regulations to the Health Insurance Act require the requesting medical practitioner to include in the request letter or note, the clinical indication for the requested procedure. The request must be personally signed by the requesting practitioner.

DIH.9 Myelogram (Item [59724](#))

Benefits are not payable where a myelogram is rendered in association with a CT myelogram (Item [56219](#) - see [DIG.5](#)). Where it is necessary to render a CT and a myelogram, CT Items [56220](#), [56221](#) and [56223](#) would apply.

DIH.10 Capital Sensitivity

From 1 July 2001, a new set of items with reduced Schedule Fees was applied to cardiac angiography services provided on equipment that is ten years old or more. This equipment must have been first installed in Australia ten or more years ago, or in the case of imported pre-used equipment, must have been first manufactured ten or more years ago.

A range of additional items has been introduced to cover services provided on older equipment. These new items are [59971](#), [59972](#), [59973](#) and [59974](#). These items are identified by the addition of the letters '(NK)' at the end of the item, and should be used where services are performed on equipment ten years old or older.

Items [59903](#), [59912](#), [59925](#) and [59970](#) have the letter '(K)' included at the end of the item. These items should be used where services are performed on equipment first installed in Australia less than ten years ago. In the case of imported pre-used equipment, the services must have been performed on a date which is less than ten years from the first date of manufacture of the equipment. Description updates have been applied to existing items to reflect these changes.

It should be noted that the letter 'K' denotes capital sensitivity rather than the letter 'C' as this letter is already in use elsewhere in the Medicare Benefits Schedule.

DIH.11 Digital Subtraction Angiography (DSA) (Items [60000-60078](#))

Benefits are payable only where these services are rendered in an angiography suite (a room that contains only equipment designed for angiography that is able to perform digital subtraction or rapid-sequence film angiography). However, benefits are not payable when these services are rendered using mobile DSA imaging equipment as these services are covered by item 59970.

Each item includes all preparation and contrast injections other than for selective catheterisation. For Digital Subtraction Angiography (DSA), benefits are payable for a maximum of 1 DSA item (from Items [60000](#) to [60069](#)). For selective DSA - 1 DSA item (from Items [60000](#) to [60069](#)) and 1 item covering selective catheterisation (from [60072](#), [60075](#) or [60078](#)).

If a DSA examination covers more than one of the specified regions/combinations, then the region/combination forming the major part of the examination should be selected, with itemisation to cover the total number of film runs obtained. A run is the injection of contrast, data acquisition, and the generation of a hard copy record.

DIH.12 Preparation Items (Items [60918](#) and [60927](#))

Benefits are not payable for preparation items when rendered with any service other than that specified in each item.

Items 60903 and 60915 were deleted on 1 July 2001 in order to reflect current clinical practice. Items [60918](#) and [60927](#) were updated to reflect the changes to the angiography and report items.

DII. NUCLEAR MEDICINE IMAGING

DII.1 General

Benefits are only payable where a nuclear medicine service is rendered by a medical specialist (see NOTE at the commencement of Group [I4](#)).

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

DII.2 Accreditation for Nuclear Medicine Imaging Services

To ensure appropriate standards for the provision of nuclear medicine imaging services, from 1 November 2000, Medicare rebates will be only available to patients of practitioners who are recognised as credentialled specialists in nuclear medicine.

Payment of Medicare rebates for nuclear medicine imaging services will be limited to medical specialists who are credentialled by the Joint Nuclear Medicine Credentialling and Accreditation Committee of the Royal Australian College of Physicians (RACP) and the Royal Australian and New Zealand College of Radiologists (RANZCR). Re-credentialling will occur on every two years.

The scheme has been developed by the profession in consultation with Government to ensure that specialists in nuclear medicine are appropriately trained and licensed, provide appropriate personal supervision of procedures and are involved in ongoing continuing medical education.

For information regarding the Scheme and for application forms, please phone the RACP or RANZCR.

DII.3 Radiopharmaceuticals

The Schedule fees for nuclear medicine imaging services incorporate the costs of radiopharmaceuticals. Sestamibi myocardial perfusion studies have now been incorporated into items in Group [I4](#).

DII.4 Single Photon Emission Tomography (SPECT)

Where SPECT has been performed in conjunction with another study and is not covered under the item descriptor or is not covered under Item 61462, no Medicare benefit is payable for the SPECT study.

DII.5 Single Myocardial Perfusion Studies (Items [61302](#) and [61303](#))

Items [61302](#) and [61303](#) apply to single myocardial perfusion studies which can only be used once and cannot be used in conjunction with any other myocardial perfusion study for an individual patient referral.

DII.6 Myocardial Perfusion (Items [61306](#) and [61307](#))

Items [61306](#) and [61307](#) refer to all myocardial perfusion studies involving two or more sets of imaging times related to an individual patient referral. This includes stress/rest, stress/re-injection, stress/rest and re-injection thallium studies, one or two-day technetium-based perfusion agent protocols, mixed technetium-based perfusion agent/thallium protocols and the use of gated SPECT when undertaken.

DII.7 Hepatobiliary Study (pre-treatment) (Item [61360](#))

Item [61360](#) - the standard hepatobiliary item - also includes allowance of the pre-procedural CCK administration for preparatory emptying of the gall bladder and also morphine augmentation.

DII.8 Hepatobiliary Study (infusion) (Item [61361](#))

Item [61361](#) applies specifically to a standard hepatobiliary study to which has been added an infusion of sinaclide (CCK-8) following which acquisition is continued and quantification of gallbladder ejection fraction and/or common bile duct activity time curves are performed.

DII.9 Whole Body Studies (Items [61426-61438](#))

"Whole body" studies must include the trunk, head and upper and lower limbs down to the elbow and knee joints respectively, whether acquired as multiple overlapping camera views or whole body sweeps (runs) with additional camera views as required. Any study that does not fulfil these criteria is a localised study.

DII.10 Repeat Studies (Item [61462](#))

Item [61462](#) covers repeat planar (whole body or localised) and/or SPECT imaging performed on a separate occasion using the same administration of radiopharmaceutical. This does not apply to bone scans, adrenal studies or gastro-oesophageal reflux studies, myocardial perfusion studies, colonic transit or CFS transport studies, where allowance for performance of the delayed study is incorporated into the baseline benefit fee. The repeat planar and SPECT imaging when performed on a separate occasion using the same administration of radiopharmaceutical should be itemised as item [61462](#) and the original item and date of service should be indicated for reference purposes.

DII.11 Thyroid Study (Item [61473](#))

Item [61473](#) incorporates the measurement of thyroid uptake on a gamma camera using a proven technique, where clinically indicated.

DIJ. MAGNETIC RESONANCE IMAGING

DIJ.1 Itemisation

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.

DIJ.2 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. Oral and maxillofacial surgeons may request Items [63621](#), [63671](#) and [63712](#) for scanning of the temporomandibular joint.

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 MRA (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.

DIJ.3 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 benefit for each item can be claimed in a 12 month period;
- * Subgroups 5, 6, 21, 23 and 24 only two benefits for each item 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.

There are limits on the number of services which can be claimed in a 12 month period for items in subgroups 17, 18, 19 and 21 will apply to the specific anatomical site being scanned. However, Medicare benefits for these subgroups will be payable for a maximum of one service per item per episode of care.

Example:

For item [63609](#), MRI scan to exclude derangement of the hip or its supporting structure, benefits would be payable for one scan performed on the right hip, within a 12 month period.

DIJ.4 Eligible services

Group I5 items apply only to a 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.

DIJ.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.

DIJ.6 Eligible providers

In group [15](#), an eligible provider is a specialist in diagnostic radiology who satisfies HIC that:

- (a) he or she is a participant in the Royal Australian and New Zealand 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 [15](#) is eligible equipment.

DIJ.7 Eligible Provider Declaration

The specialist must give HIC a statutory declaration:

- (a) stating that he or she is enrolled in the RANZCR Quality and Accreditation Program;
- (b) specifying the location of the MRI equipment;
- (c) specifying the kinds of diagnostic imaging procedure offered at that location;
- (d) stating the date of installation of the equipment (and time of installation if this occurred on 12 May 1998); and
- (e) if the equipment had not been installed before 7.30pm on 12 May 1998 (Eastern Standard Time), the specialist must also give HIC a copy of the contract for the purchase or lease of the equipment.

In addition, HIC may request further supporting documentation of information. Specialists are advised to contact the Provider Liaison Section, HIC on 132 150 prior to lodging a declaration.

DIJ.8 Eligible equipment

An eligible service must be provided within a medical practice, or the radiology department of a hospital that offers a comprehensive range of alternative diagnostic imaging procedures. A minimum of diagnostic x-ray, ultrasound and computed tomography (CT) is needed to meet this requirement.

As from 1 November 1999, for a medical practice or hospital located in a metropolitan area, the equipment must:

- (a) have been installed in a medical practice, or hospital, in Australia before 7.30pm on 12 May 1998, Eastern Standard Time; or
- (b) if uninstalled at the time on that day - have been purchased or leased under a contract, in writing (that did not contain an option to cancel), before 10 February 1998;
- (c) be replacement equipment for equipment mentioned in paragraph (a) or (b); or (d) be a unit granted eligibility under the "MRI Additional Units Eligibility Scheme".

There is an exemption to protect patients requiring MRI scans in non-metropolitan areas. For a medical practice or hospital located in a non-metropolitan area:

- (a) the equipment must have been installed in a medical practice, or hospital, in Australia before 7.30pm on 12 May 1998, Eastern Standard Time; or
- (b) if the equipment was uninstalled at the time and on the day mentioned in paragraph (a) - it must:
 - (i) have been purchased or leased under a contract, in writing (that did not contain an option to cancel) before that time on that day; and
 - (ii) on or before 18 October 1999 - be in use for services for which a Medicare benefit is claimed;
- (c) be replacement equipment for equipment mentioned in paragraph (a) or (b).

Irrespective of locations:

- The Commission must have been given on or before 11 October 1999 a statutory declaration in relation to the equipment, and (if the unit was not installed by 7.30pm on 12 May 1998, Eastern Standard Time) a copy of the contract, as required by the regulations; and

- Once equipment is replaced the original equipment ceases to be eligible equipment.

Metropolitan area includes any location within any of the Sydney, Melbourne, Brisbane, Adelaide, Perth, Greater Hobart, Darwin, or Canberra major statistical divisions, as defined in the Australian Standard Geographic Classification 1999 published by the Australian Bureau of Statistics (publication number 1216.0 of 1999.)

Information about eligible MRI sites or eligibility requirements may be obtained from the Provider Liaison Section, HIC, on 132 150.

ULTRASOUND		GENERAL
GROUP 11 - ULTRASOUND		
SUBGROUP 1 - GENERAL		
55028	<p>HEAD, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>	
55029	<p>HEAD, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55030	<p>ORBITAL CONTENTS, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>	
55031	<p>ORBITAL CONTENTS, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55032	<p>NECK, 1 or more structures of, ultrasound scan of, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>	
55033	<p>NECK, 1 or more structures of, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55036	<p>ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55038, 55044 or 55731 on the same patient within 24 hours (R) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70</p>	
55037	<p>ABDOMEN, ultrasound scan of, including scan of urinary tract when undertaken but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55038	<p>URINARY TRACT, ultrasound scan of but not being a service associated with the service described in item 55600 or item 55603, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55036, 55044 or 55731 on the same patient within 24 hours (R) <i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>	

ULTRASOUND		CARDIAC
55039	<p>URINARY TRACT, ultrasound scan of, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55044	<p>PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies;</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(c) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$101.95 Benefit: 75% = \$76.50 85% = \$86.70</p>	
55045	<p>PELVIS, male, ultrasound scan of, by any or all approaches, but not being a service associated with the service described in item 55600 or item 55603, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55048	<p>SCROTUM, ultrasound scan of, where:</p> <p>(a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$100.30 Benefit: 75% = \$75.25 85% = \$85.30</p>	
55049	<p>SCROTUM, ultrasound scan of, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 of this Group applies (NR) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	
55054	<p>ULTRASONIC CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this Group applies (R) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>	
55070	<p>BREAST, one, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$90.00 Benefit: 75% = \$67.50 85% = \$76.50</p>	
55073	<p>BREAST, one, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)</p> <p>Fee: \$31.20 Benefit: 75% = \$23.40 85% = \$26.55</p>	
55076	<p>BREASTS, both, ultrasound scan of, where: (a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R)</p> <p>Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>	
55079	<p>BREASTS, both, ultrasound scan of, where: (a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>	

ULTRASOUND	VASCULAR
SUBGROUP 2 - CARDIAC	
55113	<p>M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of cardiac failure, or suspected or known ventricular hypertrophy or dysfunction, or chest pain (R)</p> <p>Fee: \$242.80 Benefit: 75% = \$182.10 85% = \$206.40</p>
55114	<p>M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of suspected or known acquired valvular, aortic, pericardial, thrombotic, or embolic disease, or heart tumour (R)</p> <p>Fee: \$242.80 Benefit: 75% = \$182.10 85% = \$206.40</p>
55115	<p>M-MODE and 2 DIMENSIONAL REAL TIME ECHOCARDIOGRAPHIC EXAMINATION of the heart from at least 2 acoustic windows, with measurement of blood flow velocities across the cardiac valves using pulsed wave and continuous wave Doppler techniques, and real time colour flow mapping from at least 2 acoustic windows, with recordings on video tape or digital medium, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup (with the exception of items 55118 and 55130), applies, for the investigation of symptoms or signs of congenital heart disease (R)</p> <p>Fee: \$242.80 Benefit: 75% = \$182.10 85% = \$206.40</p>
55116	<p>EXERCISE STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before exercise (baseline) from at least three acoustic windows and matching recordings from the same windows at, or immediately after, peak exercise, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R)</p> <p>Fee: \$270.00 Benefit: 75% = \$202.50 85% = \$229.50</p>
55117	<p>PHARMACOLOGICAL STRESS ECHOCARDIOGRAPHY performed in conjunction with item 11712, with two-dimensional recordings before drug infusion (baseline) from at least three acoustic windows and matching recordings from the same windows at least twice during drug infusion, including a recording at the peak drug dose not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, or another item in this Subgroup, applies (with the exception of items 55118 and 55130). Recordings must be made on digital media with equipment permitting display of baseline and matching peak images on the same screen (R)</p> <p>Fee: \$270.00 Benefit: 75% = \$202.50 85% = \$229.50</p>
55118	<p>HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level, with:</p> <ul style="list-style-type: none"> (a) pulsed wave Doppler examination; (b) real time colour flow mapping; and (c) recordings on video tape or digital medium; and <p>not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, applies (R) (Anaes.) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$290.00 Benefit: 75% = \$217.50 85% = \$246.50</p>
55130	<p>INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure (R) (Anaes.) (See para DIF, of explanatory notes to this Category)</p> <p>Fee: \$353.60 Benefit: 75% = \$265.20 85% = \$300.60</p>
SUBGROUP 3 - VASCULAR	
55238	<p>DUPLEX SCANNING, unilateral, involving B mode ultrasound imaging and integrated Doppler flow measurements by spectral analysis of arteries or bypass grafts in the lower limb OR of arteries and bypass grafts in the lower limb, below the inguinal ligament, not being a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 4 of this Group applies - (R)</p> <p>Fee: \$155.25 Benefit: 75% = \$116.45 85% = \$132.00</p>

SUBGROUP 5 - OBSTETRIC AND GYNAECOLOGICAL

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and
 (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
 (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
 (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member;
 and
 (e) one or more of the following conditions are present:
 (i) hyperemesis gravidarum;
 (ii) diabetes mellitus;
 (iii) hypertension;
 (iv) toxaemia of pregnancy;
 (v) liver or renal disease;
 (vi) autoimmune disease;
 (vii) cardiac disease;
 (viii) alloimmunisation;
 (ix) maternal infection;
 (x) inflammatory bowel disease;
 (xi) bowel stoma;
 (xii) abdominal wall scarring;
 (xiii) previous spinal or pelvic trauma or disease;
 (xiv) drug dependency;
 (xv) thrombophilia;
 (xvi) significant maternal obesity;
 (xvii) advanced maternal age;
 (xviii) abdominal pain or mass;
 (xix) uncertain dates;
 (xx) high risk pregnancy;
 (xxi) previous post dates delivery;
 (xxii) previous caesarean section;
 (xxiii) poor obstetric history;
 (xxiv) suspicion of ectopic pregnancy;
 (xxv) risk of miscarriage;
 (xxvi) diminished symptoms of pregnancy;
 (xxvii) suspected or known cervical incompetence;
 (xxviii) suspected or known uterine abnormality;
 (xxix) pregnancy after assisted reproduction;
 (xxx) risk of fetal abnormality (R)

55700

Fee: \$60.00

Benefit: 75% = \$45.00

85% = \$51.00

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, ultrasound scan of, by any or all approaches, where: (a) the patient is not referred by a medical practitioner; and
 (b) the dating of the pregnancy (as confirmed by ultrasound) is less than 12 weeks of gestation; and
 (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
 (d) one or more of the following conditions are present:

- (i) hyperemesis gravidarum;
- (ii) diabetes mellitus;
- (iii) hypertension;
- (iv) toxaemia of pregnancy;
- (v) liver or renal disease;
- (vi) autoimmune disease;
- (vii) cardiac disease;
- (viii) alloimmunisation;
- (ix) maternal infection;
- (x) inflammatory bowel disease;
- (xi) bowel stoma;
- (xii) abdominal wall scarring;
- (xiii) previous spinal or pelvic trauma or disease;
- (xiv) drug dependency;
- (xv) thrombophilia;
- (xvi) significant maternal obesity;
- (xvii) advanced maternal age;
- (xviii) abdominal pain or mass;
- (xix) uncertain dates;
- (xx) high risk pregnancy;
- (xxi) previous post dates delivery;
- (xxii) previous caesarean section;
- (xxiii) poor obstetric history;
- (xxiv) suspicion of ectopic pregnancy;
- (xxv) risk of miscarriage;
- (xxvi) diminished symptoms of pregnancy;
- (xxvii) suspected or known cervical incompetence;
- (xxviii) suspected or known uterine abnormality; (xxix) pregnancy after assisted reproduction;
- (xxx) risk of fetal abnormality (NR)

55703

Fee: \$35.00

Benefit: 75% = \$26.25

85% = \$29.75

PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:
 (a) the patient is referred by a medical practitioner; and
 (b) the dating of the pregnancy (as confirmed by ultrasound) is 12 to 16 weeks of gestation; and
 (c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and
 (d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member;
 and
 (e) one or more of the following conditions are present: (i) hyperemesis gravidarum;
 (ii) diabetes mellitus;
 (iii) hypertension;
 (iv) toxaemia of pregnancy;
 (v) liver or renal disease;
 (vi) autoimmune disease;
 (vii) cardiac disease;
 (viii) alloimmunisation;
 (ix) maternal infection;
 (x) inflammatory bowel disease;
 (xi) bowel stoma;
 (xii) abdominal wall scarring;
 (xiii) previous spinal or pelvic trauma or disease;
 (xiv) drug dependency;
 (xv) thrombophilia;
 (xvi) significant maternal obesity;
 (xvii) advanced maternal age;
 (xviii) abdominal pain or mass;
 (xix) uncertain dates;
 (xx) high risk pregnancy;
 (xxi) previous post dates delivery;
 (xxii) previous caesarean section;
 (xxiii) poor obstetric history;
 (xxiv) suspicion of ectopic pregnancy;
 (xxv) risk of miscarriage;
 (xxvi) diminished symptoms of pregnancy;
 (xxvii) suspected or known cervical incompetence;
 (xxviii) suspected or known uterine abnormality;
 (xxix) pregnancy after assisted reproduction;
 (xxx) risk of fetal abnormality (R)

55704

Fee: \$70.00

Benefit: 75% = \$52.50

85% = \$59.50

	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and</p> <p>(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(e) the service is not performed in the same pregnancy as item 55723; and</p> <p>(f) one or more of the following conditions are present:</p> <ul style="list-style-type: none"> (i) known or suspected fetal abnormality or fetal cardiac arrhythmia; (ii) fetal anatomy (late booking or incomplete mid-trimester scan); (iii) malpresentation; (iv) cervical assessment; (v) clinical suspicion of amniotic fluid abnormality; (vi) clinical suspicion of placental or umbilical cord abnormality; (vii) previous complicated delivery; (viii) uterine scar assessment; (ix) uterine fibroid; (x) previous fetal death in utero or neonatal death; (xi) antepartum haemorrhage; (xii) clinical suspicion of intrauterine growth retardation; (xiii) clinical suspicion of macrosomia; (xiv) reduced fetal movements; (xv) suspected fetal death; (xvi) abnormal cardiotocography; (xvii) prolonged pregnancy; (xviii) premature labour; (xix) fetal infection; (xx) pregnancy after assisted reproduction; (xxi) trauma; (xxii) diabetes mellitus; (xxiii) hypertension; (xxiv) toxoemia of pregnancy; (xxv) liver or renal disease; (xxvi) autoimmune disease; (xxvii) cardiac disease; (xxviii) alloimmunisation; (xxix) maternal infection; (xxx) inflammatory bowel disease; (xxxi) bowel stoma; (xxxii) abdominal wall scarring; (xxxiii) previous spinal or pelvic trauma or disease; (xxxiv) drug dependency; (xxxv) thrombophilia; (xxxvi) significant maternal obesity; (xxxvii) advanced maternal age; (xxxviii) abdominal pain or mass (R) <p>55718 Fee: \$100.00 Benefit: 75% = \$75.00 85% = \$85.00</p>
<p>55721</p>	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and</p> <p>(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(e) further examination is clinically indicated in the same pregnancy to which item 55718 or 55723 applies (R) (<i>See para DIF, of explanatory notes to this Category</i>)</p> <p>55721 Fee: \$115.00 Benefit: 75% = \$86.25 85% = \$97.75</p>

ULTRASOUND

OBSTETRIC AND GYNAECOLOGICAL

55728	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner who is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and</p> <p>(b) the dating of the pregnancy (as confirmed by ultrasound) is after 22 weeks of gestation; and</p> <p>(c) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(d) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(e) it can be demonstrated that a clinical condition other than a condition mentioned in paragraph (f) of item 55718 or paragraph (e) of item 55723 is present (R)</p> <p><i>(See para DIF, of explanatory notes to this Category)</i></p> <p>Fee: \$100.00 Benefit: 75% = \$75.00 85% = \$85.00</p>
55729	<p>MEASUREMENT OF UMBILICAL BLOOD FLOW using pulsed wave or continuous wave Doppler techniques after the 26th week of gestation where the patient is referred by a medical practitioner for this procedure and where there is reason to suspect intrauterine growth retardation or a significant risk of foetal death, not being a service associated with a service to which an item in this Group applies - (R)</p> <p>Fee: \$27.25 Benefit: 75% = \$20.45 85% = \$23.20</p>
55731	<p>PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(d) the service is not performed with item 55036 or 55038 on the same patient within 24 hours (R)</p> <p>Fee: \$98.00 Benefit: 75% = \$73.50 85% = \$83.30</p>
55733	<p>PELVIS, FEMALE, ultrasound scan of, by any or all approaches, where:</p> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies (NR)</p> <p>Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75</p>
55736	<p>PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) the referring medical practitioner is not a member of a group of medical practitioners of which the providing practitioner is a member; and</p> <p>(d) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (R)</p> <p>Fee: \$127.00 Benefit: 75% = \$95.25 85% = \$107.95</p>
55739	<p>PELVIS, FEMALE, ultrasound scan of, in association with saline infusion of the endometrial cavity, by any or all approaches, where:</p> <p>(a) the patient is not referred by a medical practitioner; and</p> <p>(b) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(c) a previous transvaginal ultrasound has revealed an abnormality of the uterus or fallopian tube (NR)</p> <p>Fee: \$57.00 Benefit: 75% = \$42.75 85% = \$48.45</p>
55759	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan (not exceeding 1 service in any 1 pregnancy) of, by any or all approaches, with measurement of all parameters for dating purposes, where:</p> <p>(a) the patient is referred by a medical practitioner; and</p> <p>(b) ultrasound of the same pregnancy confirms a multiple pregnancy; and</p> <p>(c) the dating of the pregnancy (as confirmed by ultrasound) is 17 to 22 weeks gestation; and</p> <p>(d) the service is not associated with a service to which an item in Subgroup 2 or 3 of this group applies; and</p> <p>(e) the referring practitioner is not a member of a group of practitioners to which the providing practitioner is a member; and</p> <p>(f) the service is not performed in conjunction with item 55706, 55709, 55712, or 55715 during the same pregnancy (R)</p> <p>Fee: \$150.00 Benefit: 75% = \$112.50 85% = \$127.50</p>

ULTRASOUND

MUSCULOSKELETAL

55772	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where:</p> <p>(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and</p> <p>(b) the patient is referred by a medical practitioner who is a Member or Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists or who has a Diploma of Obstetrics or has obstetric privileges at a non-metropolitan hospital; and</p> <p>(c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and</p> <p>(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and</p> <p>(e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and</p> <p>(f) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and</p> <p>(g) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy</p> <p>(R)</p> <p>Fee: \$160.00 Benefit: 75% = \$120.00 85% = \$136.00</p>
55774	<p>PELVIS OR ABDOMEN, pregnancy related or pregnancy complication, fetal development and anatomy, ultrasound scan of, by any or all approaches, where the providing practitioner is a Member or a Fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, where:</p> <p>(a) dating of the pregnancy as confirmed by ultrasound is after 22 weeks of gestation; and</p> <p>(b) the patient is not referred by a medical practitioner; and</p> <p>(c) further examination is clinically indicated in the same pregnancy to which item 55768 or 55770 has been performed; and</p> <p>(d) the pregnancy as confirmed by ultrasound is a multiple pregnancy; and</p> <p>(e) the service is not associated with a service to which an item in Subgroups 2 or 3 of this group applies; and</p> <p>(f) the service is not performed in conjunction with item 55718, 55721, 55723, 55725 or 55728 during the same pregnancy</p> <p>(NR)</p> <p>Fee: \$65.00 Benefit: 75% = \$48.75 85% = \$55.25</p>
SUBGROUP 6 - MUSCULOSKELETAL	
55800	<p>HAND OR WRIST, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member</p> <p>(R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>
55802	<p>HAND OR WRIST, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>
55804	<p>FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member</p> <p>(R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>
55806	<p>FOREARM OR ELBOW, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>
55808	<p>SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member.</p> <p>(R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>
55810	<p>SHOULDER OR UPPER ARM, 1 or both sides, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the patient is not referred by a medical practitioner (NR)</p> <p>Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50</p>
55812	<p>CHEST OR ABDOMINAL WALL, 1 or more areas, ultrasound scan of, where:</p> <p>(a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and</p> <p>(b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member</p> <p>(R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95</p>

ULTRASOUND	MUSCULOSKELETAL
55840	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95
55842	MID FOOT OR FORE FOOT, 1 or both sides, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50
55844	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) Fee: \$80.00 Benefit: 75% = \$60.00 85% = \$68.00
55846	ASSESSMENT OF A MASS ASSOCIATED WITH THE SKIN OR SUBCUTANEOUS STRUCTURES, NOT BEING A PART OF THE MUSCULOSKELETAL SYSTEM, 1 or more areas, ultrasound scan of, where: (a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and (b) the patient is not referred by a medical practitioner (NR) Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50
55848	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which any other item in this group applies, and not performed in conjunction with item 55054 (R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95
55850	MUSCULOSKELETAL CROSS-SECTIONAL ECHOGRAPHY, in conjunction with a surgical procedure using interventional techniques, inclusive of a diagnostic musculoskeletal ultrasound service, where: (a) the referring practitioner has indicated on a referral for a musculoskeletal ultrasound that a ultrasound guided intervention be performed if clinically indicated; (b) the service is not performed in conjunction with items 55054 , or 55800 to 55848 , and (c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00
55852	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the patient is referred by a medical practitioner b) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and c) the referring practitioner is not a member of a group of practitioners of which the providing practitioner is a member (R) Fee: \$99.90 Benefit: 75% = \$74.95 85% = \$84.95
55854	PAEDIATRIC SPINE, SPINAL CORD AND OVERLYING SUBCUTANEOUS TISSUES, Ultrasound scan of, where: a) the service is not associated with a service to which an item in Subgroups 2 or 3 of this Group applies; and b) the patient is not referred by a medical practitioner (NR) Fee: \$34.65 Benefit: 75% = \$26.00 85% = \$29.50

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY	
GROUP I2 - COMPUTED TOMOGRAPHY			
HEAD			
56001	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57001 applies (R) (K) (Anaes.) Fee: \$185.25	Benefit: 75% = \$138.95	85% = \$157.50
56007	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57007 applies (R) (K) (Anaes.) Fee: \$237.50	Benefit: 75% = \$178.15	85% = \$201.90
56010	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) Fee: \$239.50	Benefit: 75% = \$179.65	85% = \$203.60
56013	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (K) (Anaes.) Fee: \$237.50	Benefit: 75% = \$178.15	85% = \$201.90
56016	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (K) (Anaes.) Fee: \$275.50	Benefit: 75% = \$206.65	85% = \$234.20
56022	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (K) (Anaes.) Fee: \$213.75	Benefit: 75% = \$160.35	85% = \$181.70
56028	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (K) (Anaes.) Fee: \$319.95	Benefit: 75% = \$240.00	85% = \$272.00
56030	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (K) (Anaes.) Fee: \$213.75	Benefit: 75% = \$160.35	85% = \$181.70
56036	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (K) (Anaes.) Fee: \$319.95	Benefit: 75% = \$240.00	85% = \$272.00
56041	COMPUTED TOMOGRAPHY - scan of brain without intravenous contrast medium, not being a service to which item 57041 applies (R) (NK) (Anaes.) Fee: \$93.80	Benefit: 75% = \$70.35	85% = \$79.75
56047	COMPUTED TOMOGRAPHY - scan of brain with intravenous contrast medium and with any scans of the brain prior to intravenous contrast injection, when undertaken, not being a service to which item 57047 applies (R) (NK) (Anaes.) Fee: \$119.80	Benefit: 75% = \$89.85	85% = \$101.85
56050	COMPUTED TOMOGRAPHY - scan of pituitary fossa with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) Fee: \$121.75	Benefit: 75% = \$91.35	85% = \$103.50
56053	COMPUTED TOMOGRAPHY - scan of orbits with or without intravenous contrast medium and with or without brain scan when undertaken (R) (NK) (Anaes.) Fee: \$121.75	Benefit: 75% = \$91.35	85% = \$103.50
56056	COMPUTED TOMOGRAPHY - scan of petrous bones in axial and coronal planes in 1 mm or 2 mm sections, with or without intravenous contrast medium, with or without scan of brain (R) (NK) (Anaes.) Fee: \$147.65	Benefit: 75% = \$110.75	85% = \$125.55
56062	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both without intravenous contrast medium (R) (NK) (Anaes.) Fee: \$107.50	Benefit: 75% = \$80.65	85% = \$91.40

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY	
56068	COMPUTED TOMOGRAPHY - scan of facial bones, para nasal sinuses or both with intravenous contrast medium and with any scans of the facial bones, para nasal sinuses or both prior to intravenous contrast injection, when undertaken (R) (NK) (Anaes.) Fee: \$160.00 Benefit: 75% = \$120.00 85% = \$136.00		
56070	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, without intravenous contrast medium (R) (NK) (Anaes.) Fee: \$107.50 Benefit: 75% = \$80.65 85% = \$91.40		
56076	COMPUTED TOMOGRAPHY - scan of facial bones, paranasal sinuses or both, with scan of brain, with intravenous contrast medium, where: (a) a scan without intravenous contrast medium has been undertaken; and (b) the service is required because the result of the scan mentioned in paragraph (a) is abnormal (R) (NK) (Anaes.) Fee: \$160.00 Benefit: 75% = \$120.00 85% = \$136.00		
NECK			
56101	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56801 applies (R) (K) (Anaes.) Fee: \$218.50 Benefit: 75% = \$163.90 85% = \$185.75		
56107	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56807 applies (R) (K) (Anaes.) Fee: \$323.00 Benefit: 75% = \$242.25 85% = \$274.55		
56141	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) without intravenous contrast medium, not being a service to which item 56841 applies (R) (NK) (Anaes.) Fee: \$110.60 Benefit: 75% = \$82.95 85% = \$94.05		
56147	COMPUTED TOMOGRAPHY - scan of soft tissues of neck, including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) - with intravenous contrast medium and with any scans of soft tissues of neck including larynx, pharynx, upper oesophagus and salivary glands (not associated with cervical spine) prior to intravenous contrast injection, when undertaken, not being a service associated with a service to which item 56847 applies (R) (NK) (Anaes.) Fee: \$163.00 Benefit: 75% = \$122.25 85% = \$138.55		
SPINE			
56219	COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$309.90 Benefit: 75% = \$232.45 85% = \$263.45		
56220	COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$228.00 Benefit: 75% = \$171.00 85% = \$193.80		
56221	COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$228.00 Benefit: 75% = \$171.00 85% = \$193.80		
56223	COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$228.00 Benefit: 75% = \$171.00 85% = \$193.80		
56224	COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium and with any scans of the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$333.80 Benefit: 75% = \$250.35 85% = \$283.75		

COMPUTED TOMOGRAPHY

COMPUTED TOMOGRAPHY

56225	<p>COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken, only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$333.80 Benefit: 75% = \$250.35 85% = \$283.75</p>
56226	<p>COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$333.80 Benefit: 75% = \$250.35 85% = \$283.75</p>
56227	<p>COMPUTED TOMOGRAPHY - scan of spine, cervical region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$116.40 Benefit: 75% = \$87.30 85% = \$98.95</p>
56228	<p>COMPUTED TOMOGRAPHY - scan of spine, thoracic region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$116.40 Benefit: 75% = \$87.30 85% = \$98.95</p>
56229	<p>COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$116.40 Benefit: 75% = \$87.30 85% = \$98.95</p>
56230	<p>COMPUTED TOMOGRAPHY - scan of spine, cervical region, with intravenous contrast medium, and with any scans to the cervical region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$168.60 Benefit: 75% = \$126.45 85% = \$143.35</p>
56231	<p>COMPUTED TOMOGRAPHY - scan of spine, thoracic region, with intravenous contrast medium and with any scans of the thoracic region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$168.60 Benefit: 75% = \$126.45 85% = \$143.35</p>
56232	<p>COMPUTED TOMOGRAPHY - scan of spine, lumbosacral region, with intravenous contrast medium and with any scans of the lumbosacral region of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$168.60 Benefit: 75% = \$126.45 85% = \$143.35</p>
56233	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56220, 56221 and 56223 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$228.00 Benefit: 75% = \$171.00 85% = \$193.80</p>
56234	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56224, 56225 and 56226 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) <i>(See para DIG. of explanatory notes to this Category)</i> Fee: \$333.80 Benefit: 75% = \$250.35 85% = \$283.75</p>

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY	
	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56227, 56228 and 56229 without intravenous contrast medium payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para DIG. of explanatory notes to this Category)</p>		
56235	Fee: \$116.35	Benefit: 75% = \$87.30	85% = \$98.90
	<p><i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i></p> <p>COMPUTED TOMOGRAPHY - scan of spine, two examinations of the kind referred to in items 56230, 56231 and 56232 with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para DIG. of explanatory notes to this Category)</p>		
56236	Fee: \$168.60	Benefit: 75% = \$126.45	85% = \$143.35
	<p>COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para DIG. DIG. of explanatory notes to this Category)</p>		
56237	Fee: \$228.00	Benefit: 75% = \$171.00	85% = \$193.80
	<p>COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para DIG. of explanatory notes to this Category)</p>		
56238	Fee: \$333.80	Benefit: 75% = \$250.35	85% = \$283.75
	<p>COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, without intravenous contrast medium, payable once only, whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para DIG. of explanatory notes to this Category)</p>		
56239	Fee: \$116.35	Benefit: 75% = \$87.30	85% = \$98.90
	<p>COMPUTED TOMOGRAPHY - scan of spine, three regions cervical, thoracic and lumbosacral, with intravenous contrast medium and with any scans of these regions of the spine prior to intravenous contrast injection when undertaken; only 1 benefit, payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.)</p>		
56240	Fee: \$168.60	Benefit: 75% = \$126.45	85% = \$143.35
	<p>COMPUTED TOMOGRAPHY - scan of spine, 1 or more regions with intrathecal contrast medium, including the preparation for intrathecal injection of contrast medium and any associated plain X-rays, not being a service to which item 59724 applies (R) (NK) (Anaes.) (See para DIG. of explanatory notes to this Category)</p>		
56259	Fee: \$156.55	Benefit: 75% = \$117.45	85% = \$133.10
	CHEST AND UPPER ABDOMEN		
	<p>COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56801 or 57001 applies and not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.)</p>		
56301	Fee: \$280.25	Benefit: 75% = \$210.20	85% = \$238.25
	<p>COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies and not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.)</p>		
56307	Fee: \$380.00	Benefit: 75% = \$285.00	85% = \$324.40
	<p>COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, without intravenous contrast medium, not being a service to which item 56841 or 57041 applies and not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.)</p>		
56341	Fee: \$142.00	Benefit: 75% = \$106.50	85% = \$120.70

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY	
56347	COMPUTED TOMOGRAPHY - scan of chest, including lungs, mediastinum, chest wall and pleura, with or without scans of the upper abdomen, with intravenous contrast medium and with any scans of the chest including lungs, mediastinum, chest wall or pleura and upper abdomen prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies and not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.)	Fee: \$191.90	Benefit: 75% = \$143.95 85% = \$163.15
UPPER ABDOMEN			
56401	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) without intravenous contrast medium, not being a service to which item 56301 , 56501 , 56801 or 57001 applies (R) (K) (Anaes.)	Fee: \$237.50	Benefit: 75% = \$178.15 85% = \$201.90
56407	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56307 , 56507 , 56807 or 57007 applies (R) (K) (Anaes.)	Fee: \$342.00	Benefit: 75% = \$256.50 85% = \$290.70
56409	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium not being a service associated with a service to which item 56401 applies (R) (K) (Anaes.)	Fee: \$237.50	Benefit: 75% = \$178.15 85% = \$201.90
56412	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56407 applies (R) (K) (Anaes.)	Fee: \$342.00	Benefit: 75% = \$256.50 85% = \$290.70
56441	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest), without intravenous contrast medium, not being a service to which item 56341 , 56541 , 56841 or 57041 applies (R) (NK) (Anaes.)	Fee: \$120.45	Benefit: 75% = \$90.35 85% = \$102.40
56447	COMPUTED TOMOGRAPHY - scan of upper abdomen only (diaphragm to iliac crest) with intravenous contrast medium, and with any scans of upper abdomen (diaphragm to iliac crest) prior to intravenous contrast injection, when undertaken, not being a service to which item 56347 , 56547 , 56847 or 57047 applies (R) (NK) (Anaes.)	Fee: \$172.40	Benefit: 75% = \$129.30 85% = \$146.55
56449	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) without intravenous contrast medium, not being a service to which item 56401 applies (R) (NK) (Anaes.)	Fee: \$120.45	Benefit: 75% = \$90.35 85% = \$102.40
56452	COMPUTED TOMOGRAPHY - scan of pelvis only (iliac crest to pubic symphysis) with intravenous contrast medium, and with any scans of pelvis (iliac crest to pubic symphysis) prior to intravenous contrast injection, when undertaken, not being a service to which item 56447 applies (R) (NK) (Anaes.)	Fee: \$172.40	Benefit: 75% = \$129.30 85% = \$146.55
UPPER ABDOMEN AND PELVIS			
56501	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.)	Fee: \$365.75	Benefit: 75% = \$274.35 85% = \$310.90
56507	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not being a service to which item 56807 or 57007 applies (R) (K) (Anaes.)	Fee: \$456.00	Benefit: 75% = \$342.00 85% = \$398.90
56541	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not being a service to which item 56841 or 57041 applies (R) (NK) (Anaes.)	Fee: \$183.45	Benefit: 75% = \$137.60 85% = \$155.95
56547	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not being a service to which item 56847 or 57047 applies (R) (NK) (Anaes.)	Fee: \$231.55	Benefit: 75% = \$173.70 85% = \$196.85

COMPUTED TOMOGRAPHY		COMPUTED TOMOGRAPHY	
EXTREMITIES			
56619	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para DIG. of explanatory notes to this Category) Fee: \$209.00	Benefit: 75% = \$156.75	85% = \$177.65
56625	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (K) (Anaes.) (See para DIG. of explanatory notes to this Category) Fee: \$317.90	Benefit: 75% = \$238.45	85% = \$270.25
56659	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions without intravenous contrast medium, payable once only whether 1 or more attendances are required to complete (R) (NK) (Anaes.) (See para DIG. of explanatory notes to this Category) Fee: \$106.50	Benefit: 75% = \$79.90	85% = \$90.55
56665	COMPUTED TOMOGRAPHY - scan of extremities, 1 or more regions with intravenous contrast medium, and with any scans of extremities prior to intravenous contrast injection, when undertaken; only 1 benefit is payable whether 1 or more attendances are required to complete the service (R) (NK) (Anaes.) (See para DIG. of explanatory notes to this Category) Fee: \$159.00	Benefit: 75% = \$119.25	85% = \$135.15
CHEST, ABDOMEN, PELVIS AND NECK			
56801	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) Fee: \$443.20	Benefit: 75% = \$332.40	85% = \$386.10
56807	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (K) (Anaes.) Fee: \$532.00	Benefit: 75% = \$399.00	85% = \$474.90
56841	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck without intravenous contrast medium not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.) Fee: \$221.65	Benefit: 75% = \$166.25	85% = \$188.45
56847	COMPUTED TOMOGRAPHY - scan of chest, abdomen and pelvis with or without scans of soft tissues of neck with intravenous contrast medium and with any scans of chest, abdomen and pelvis with or without scans of soft tissue of neck prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification (R) (NK) (Anaes.) Fee: \$269.65	Benefit: 75% = \$202.25	85% = \$229.25
BRAIN, CHEST AND UPPER ABDOMEN			
57001	COMPUTED TOMOGRAPHY - scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification (R) (K) (Anaes.) Fee: \$443.30	Benefit: 75% = \$332.50	85% = \$386.20
57007	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (K) (Anaes.) Fee: \$539.35	Benefit: 75% = \$404.55	85% = \$482.25
57041	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen without intravenous contrast medium, not including a study performed to exclude coronary artery calcification(R) (NK) (Anaes.) Fee: \$221.70	Benefit: 75% = \$166.30	85% = \$188.45
57047	COMPUTED TOMOGRAPHY- scan of brain and chest with or without scans of upper abdomen with intravenous contrast medium and with any scans of brain and chest and upper abdomen prior to intravenous contrast injection, when undertaken, not including a study performed to exclude coronary artery calcification(R) (NK) (Anaes.) Fee: \$269.70	Benefit: 75% = \$202.30	85% = \$229.25

		PELVIMETRY	
57201	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (K) (Anaes.) Fee: \$147.45	Benefit: 75% = \$110.60	85% = \$125.35
57247	COMPUTED TOMOGRAPHY - PELVIMETRY (R) (NK) (Anaes.) Fee: \$73.70	Benefit: 75% = \$55.30	85% = \$62.65
		INTERVENTIONAL TECHNIQUES	
57341	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (K) (Anaes.) Fee: \$446.50	Benefit: 75% = \$334.90	85% = \$389.40
57345	COMPUTED TOMOGRAPHY, in conjunction with a surgical procedure using interventional techniques, not being a service associated with a service to which another item in this table applies (R) (NK) (Anaes.) Fee: \$229.50	Benefit: 75% = \$172.15	85% = \$195.10
		SPIRAL ANGIOGRAPHY	
57350	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months (R) (K) (Anaes.) Fee: \$484.50	Benefit: 75% = \$363.40	85% = \$427.40
57351	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of: acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; acute ruptured aneurysm; or acute dissection of the aorta, carotid or vertebral artery; and c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months. (R) (K) (Anaes.) Fee: \$484.50	Benefit: 75% = \$363.40	85% = \$427.40
57355	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: (a) the service is not a service to which another item in this group applies; and (b) the service is performed for the exclusion of arterial stenosis, occlusion, aneurysm or embolism; and (c) the service has not been performed on the same patient within the previous 12 months (R) (NK) (Anaes.) Fee: \$250.95	Benefit: 75% = \$188.25	85% = \$213.35
57356	COMPUTED TOMOGRAPHY - spiral angiography with intravenous contrast medium, including any scans performed before intravenous contrast injection - 1 or more spiral data acquisitions, including image editing, and maximum intensity projections or 3 dimensional surface shaded display, with hardcopy recording of multiple projections, where: a) the service is not a service to which another item in this group applies; and b) the service is performed for the exclusion of: acute or recurrent pulmonary embolism; acute symptomatic arterial occlusion; post operative complication of arterial surgery; or acute ruptured aneurysm; acute dissection of the aorta, carotid or vertebral artery; and c) the services to which 57350 or 57355 apply have been performed on the same patient within the previous 12 months. (R) (NK) (Anaes.) Fee: \$250.95	Benefit: 75% = \$188.25	85% = \$213.35

DIAGNOSTIC RADIOLOGY		EXTREMITIES
GROUP 13 - DIAGNOSTIC RADIOLOGY		
SUBGROUP 1 - RADIOGRAPHIC EXAMINATION OF EXTREMITIES		
57506	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (NR) Fee: \$28.05 Benefit: 75% = \$21.05 85% = \$23.85	
57509	HAND, WRIST, FOREARM, ELBOW OR HUMERUS (R) Fee: \$37.50 Benefit: 75% = \$28.15 85% = \$31.90	
57512	HAND, WRIST AND FOREARM, OR FOREARM AND ELBOW, OR ELBOW AND HUMERUS (NR) Fee: \$38.15 Benefit: 75% = \$28.65 85% = \$32.45	
57515	HAND, WRIST AND FOREARM, OR FOREARM AND ELBOW, OR ELBOW AND HUMERUS (R) Fee: \$50.90 Benefit: 75% = \$38.20 85% = \$43.30	
57518	FOOT, ANKLE, LEG, KNEE OR FEMUR (NR) Fee: \$30.65 Benefit: 75% = \$23.00 85% = \$26.10	
57521	FOOT, ANKLE, LEG, KNEE OR FEMUR (R) Fee: \$40.90 Benefit: 75% = \$30.70 85% = \$34.80	
57524	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (NR) Fee: \$46.55 Benefit: 75% = \$34.95 85% = \$39.60	
57527	FOOT AND ANKLE, OR ANKLE AND LEG, OR LEG AND KNEE, OR KNEE AND FEMUR (R) Fee: \$62.00 Benefit: 75% = \$46.50 85% = \$52.70	
SUBGROUP 2 - RADIOGRAPHIC EXAMINATION OF SHOULDER OR PELVIS		
57700	SHOULDER OR SCAPULA (NR) Fee: \$38.15 Benefit: 75% = \$28.65 85% = \$32.45	
57703	SHOULDER OR SCAPULA (R) Fee: \$50.90 Benefit: 75% = \$38.20 85% = \$43.30	
57706	CLAVICLE (NR) Fee: \$30.65 Benefit: 75% = \$23.00 85% = \$26.10	
57709	CLAVICLE (R) Fee: \$40.90 Benefit: 75% = \$30.70 85% = \$34.80	
57712	HIP JOINT (R) Fee: \$44.45 Benefit: 75% = \$33.35 85% = \$37.80	
57715	PELVIC GIRDLE (R) Fee: \$57.45 Benefit: 75% = \$43.10 85% = \$48.85	
57721	FEMUR, internal fixation of neck or intertrochanteric (pertrochanteric) fracture (R) Fee: \$93.55 Benefit: 75% = \$70.20 85% = \$79.55	
SUBGROUP 3 - RADIOGRAPHIC EXAMINATION OF HEAD		
57901	SKULL, not in association with item 57902 (R) Fee: \$60.80 Benefit: 75% = \$45.60 85% = \$51.70	
57902	CEPHALOMETRY, not in association with item 57901 (R) Fee: \$60.80 Benefit: 75% = \$45.60 85% = \$51.70	
57903	SINUSES (R) Fee: \$44.55 Benefit: 75% = \$33.45 85% = \$37.90	
57906	MASTOIDS (R) Fee: \$60.80 Benefit: 75% = \$45.60 85% = \$51.70	
57909	PETROUS TEMPORAL BONES (R) Fee: \$60.80 Benefit: 75% = \$45.60 85% = \$51.70	

DIAGNOSTIC RADIOLOGY		BONE AGE STUDY	
	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i>		
58112	Spine, two examinations of the kind referred to in items 58100 , 58103 , 58106 and 58109 (R) Fee: \$91.65	Benefit: 75% = \$68.75	85% = \$77.95
	<i>NOTE: An account issued or a patient assignment form must show the item numbers of the examinations performed under this item</i>		
58115	Spine, three examinations of the kind mentioned in items 58100, 58103, 58106 and 58109 (R) Fee: \$125.30	Benefit: 75% = \$94.00	85% = \$106.55
SUBGROUP 5 - BONE AGE STUDY AND SKELETAL SURVEYS			
58300	BONE AGE STUDY (R) Fee: \$37.80	Benefit: 75% = \$28.35	85% = \$32.15
58306	SKELETAL SURVEY (R) Fee: \$84.25	Benefit: 75% = \$63.20	85% = \$71.65
SUBGROUP 6 - RADIOGRAPHIC EXAMINATION OF THORACIC REGION			
58500	CHEST (lung fields) by direct radiography (NR) Fee: \$33.30	Benefit: 75% = \$25.00	85% = \$28.35
58503	CHEST (lung fields) by direct radiography (R) Fee: \$44.45	Benefit: 75% = \$33.35	85% = \$37.80
58506	CHEST (lung fields) by direct radiography with fluoroscopic screening (R) Fee: \$57.30	Benefit: 75% = \$43.00	85% = \$48.75
58509	THORACIC INLET OR TRACHEA (R) Fee: \$37.50	Benefit: 75% = \$28.15	85% = \$31.90
58521	LEFT RIBS, RIGHT RIBS OR STERNUM (R) Fee: \$40.90	Benefit: 75% = \$30.70	85% = \$34.80
58524	LEFT AND RIGHT RIBS, LEFT RIBS AND STERNUM, OR RIGHT RIBS AND STERNUM (R) Fee: \$53.25	Benefit: 75% = \$39.95	85% = \$45.30
58527	LEFT RIBS, RIGHT RIBS AND STERNUM (R) Fee: \$65.45	Benefit: 75% = \$49.10	85% = \$55.65
SUBGROUP 7 - RADIOGRAPHIC EXAMINATION OF URINARY TRACT			
58700	PLAIN RENAL ONLY (R) Fee: \$43.40	Benefit: 75% = \$32.55	85% = \$36.90
58706	INTRAVENOUS PYELOGRAPHY, with or without preliminary plain films and with or without tomography - (R) Fee: \$148.85	Benefit: 75% = \$111.65	85% = \$126.55
58715	ANTEGRADE OR RETROGRADE PYELOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - 1 side - (R) Fee: \$142.85	Benefit: 75% = \$107.15	85% = \$121.45
58718	RETROGRADE CYSTOGRAPHY OR RETROGRADE URETHROGRAPHY with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) Fee: \$118.90	Benefit: 75% = \$89.20	85% = \$101.10
58721	RETROGRADE MICTURATING CYSTOURETHROGRAPHY, with preparation and contrast injection - (R) (Anaes.) Fee: \$130.30	Benefit: 75% = \$97.75	85% = \$110.80
SUBGROUP 8 - RADIOGRAPHIC EXAMINATION OF ALIMENTARY TRACT AND BILIARY SYSTEM			
58900	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909 , 58912 , 58915 or 58924 applies (NR) <i>(See para DIJ. of explanatory notes to this Category)</i> Fee: \$33.65	Benefit: 75% = \$25.25	85% = \$28.65

DIAGNOSTIC RADIOLOGY **LOCALISATION OF FOREIGN BODIES**

58903	PLAIN ABDOMINAL ONLY, not being a service associated with a service to which item 58909 , 58912 , 58915 or 58924 applies (R) <i>(See para DIH, of explanatory notes to this Category)</i> Fee: \$44.85 Benefit: 75% = \$33.65 85% = \$38.15
58909	BARIUM or other opaque meal of 1 or more of PHARYNX, OESOPHAGUS, STOMACH OR ABDOMEN, with or without preliminary plain films of pharynx, chest or duodenum, not being a service associated with a service to which item 57939 or 57942 or 57945 applies - (R) Fee: \$84.80 Benefit: 75% = \$63.60 85% = \$72.10
58912	BARIUM or other opaque meal OF OESOPHAGUS, STOMACH, DUODENUM AND FOLLOW THROUGH TO COLON, with or without screening of chest, with or without preliminary plain film (R) Fee: \$103.95 Benefit: 75% = \$78.00 85% = \$88.40
58915	BARIUM or other opaque meal, SMALL BOWEL SERIES ONLY, with or without preliminary plain film (R) Fee: \$74.40 Benefit: 75% = \$55.80 85% = \$63.25
58916	SMALL BOWEL ENEMA, barium or other opaque study of the small bowel, including DUODENAL INTUBATION, with or without preliminary plain films, not being a service associated with a service to which item 30488 applies - (R) (Anaes.) Fee: \$130.55 Benefit: 75% = \$97.95 85% = \$111.00
58921	OPAQUE ENEMA, with or without air contrast study and with or without preliminary plain films - (R) Fee: \$127.50 Benefit: 75% = \$95.65 85% = \$108.40
58924	GRAHAM'S TEST (cholecystography), with preliminary plain films and with or without tomography - (R) Fee: \$79.20 Benefit: 75% = \$59.40 85% = \$67.35
58927	CHOLEGRAPHY DIRECT, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 30439 applies - (R) Fee: \$72.05 Benefit: 75% = \$54.05 85% = \$61.25
58933	CHOLEGRAPHY, percutaneous transhepatic, with or without preliminary plain films and with preparation and contrast injection - (R) Fee: \$193.80 Benefit: 75% = \$145.35 85% = \$164.75
58936	CHOLEGRAPHY, drip infusion, with or without preliminary plain films, with preparation and contrast injection and with or without tomography - (R) Fee: \$184.70 Benefit: 75% = \$138.55 85% = \$157.00
58939	DEFAECOGRAM (R) Fee: \$131.30 Benefit: 75% = \$98.50 85% = \$111.65
SUBGROUP 9 - RADIOGRAPHIC EXAMINATION FOR LOCALISATION OF FOREIGN BODIES	
59103	FOREIGN BODY, LOCALISATION OF AND REPORT, not being a service to which another item in this Group applies (R) Derived Fee: The fee for radiographic examination of the area and report plus an amount of \$21.30
SUBGROUP 10 - RADIOGRAPHIC EXAMINATION OF BREASTS	
<i>(Note: These items are intended for use in the investigation of a clinical abnormality of the breast/s and NOT for individual, group or opportunistic screening of asymptomatic patients)</i>	
59300	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, (with or without thermography) if: (a) the patient is referred with a specific request for this procedure; and (b) there is reason to suspect the presence of malignancy in the breasts because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) <i>(See para DIH, of explanatory notes to this Category)</i> Fee: \$82.00 Benefit: 75% = \$61.50 85% = \$69.70
59303	RADIOGRAPHIC EXAMINATION OF 1 BREAST, (with or without thermography) if: (a) the patient is referred with a specific request for this procedure; and (b) there is reason to suspect the presence of malignancy in the breasts because of: (i) the past occurrence of breast malignancy in the patient or members of the patient's family; or (ii) symptoms or indications of malignancy found on an examination of the patient by a medical practitioner (R) <i>(See para DIH, of explanatory notes to this Category)</i> Fee: \$49.45 Benefit: 75% = \$37.10 85% = \$42.05

DIAGNOSTIC RADIOLOGY		IN CONNECTION WITH PREGNANCY	
59306	MAMMARY DUCTOGRAM (galactography) - 1 breast (R) Fee: \$94.55 Benefit: 75% = \$70.95	85% = \$80.40	
59309	MAMMARY DUCTOGRAM (galactography) - 2 breasts (R) Fee: \$189.10 Benefit: 75% = \$141.85	85% = \$160.75	
59312	RADIOGRAPHIC EXAMINATION OF BOTH BREASTS, in conjunction with a surgical procedure on each breast, using interventional techniques - (R) Fee: \$82.00 Benefit: 75% = \$61.50	85% = \$69.70	
59314	RADIOGRAPHIC EXAMINATION OF 1 BREAST, in conjunction with a surgical procedure using interventional techniques - (R) Fee: \$49.45 Benefit: 75% = \$37.10	85% = \$42.05	
59318	RADIOGRAPHIC EXAMINATION OF EXCISED BREAST TISSUE to confirm satisfactory excision of 1 or more lesions in 1 breast or both following pre-operative localisation in conjunction with a service under item 30361 - (R) Fee: \$44.35 Benefit: 75% = \$33.30	85% = \$37.70	
SUBGROUP 11 - RADIOGRAPHIC EXAMINATION IN CONNECTION WITH PREGNANCY			
59503	PELVIMETRY, not being a service associated with a service to which item 57201 applies (R) Fee: \$84.25 Benefit: 75% = \$63.20	85% = \$71.65	
SUBGROUP 12 - RADIOGRAPHIC EXAMINATION WITH OPAQUE OR CONTRAST MEDIA			
59700	DISCOGRAPHY, each disc, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) Fee: \$91.00 Benefit: 75% = \$68.25	85% = \$77.35	
59703	DACRYOCYSTOGRAPHY, 1 side, with or without preliminary plain film and with preparation and contrast injection - (R) Fee: \$71.55 Benefit: 75% = \$53.70	85% = \$60.85	
59712	HYSTEROSALPINGOGRAPHY, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) Fee: \$107.20 Benefit: 75% = \$80.40	85% = \$91.15	
59715	BRONCHOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) Fee: \$135.30 Benefit: 75% = \$101.50	85% = \$115.05	
59718	PHLEBOGRAPHY, 1 side, with or without preliminary plain films and with preparation and contrast injection - (R) (Anaes.) Fee: \$126.95 Benefit: 75% = \$95.25	85% = \$107.95	
59724	MYELOGRAPHY, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection, not being a service associated with a service to which item 56219 applies - (R) (Anaes.) <i>(See para DIH of explanatory notes to this Category)</i> Fee: \$213.45 Benefit: 75% = \$160.10	85% = \$181.45	
59733	SIALOGRAPHY, 1 side, with preparation and contrast injection, not being a service associated with a service to which item 57918 applies - (R) Fee: \$101.50 Benefit: 75% = \$76.15	85% = \$86.30	
59736	VASOEPIDIDYMOGRAPHY, 1 side, for other than an investigation for reversal of previous sterilisation - (R) Fee: \$58.45 Benefit: 75% = \$43.85	85% = \$49.70	
59739	SINOGRAM OR FISTULOGRAM, 1 or more regions, with or without preliminary plain films and with preparation and contrast injection - (R) Fee: \$69.50 Benefit: 75% = \$52.15	85% = \$59.10	
59751	ARTHROGRAPHY, each joint, excluding the facet (zygapophyseal) joints of the spine, single or double contrast study, with or without preliminary plain films and with preparation and contrast injection - (R) Fee: \$131.15 Benefit: 75% = \$98.40	85% = \$111.50	
59754	LYMPHANGIOGRAPHY, one or both sides, with preliminary plain films and follow-up radiography and with preparation and contrast injection - (R) Fee: \$206.75 Benefit: 75% = \$155.10	85% = \$175.75	
59760	PERITONEOGRAM (herniography) with or without contrast medium including preparation - performed on a person over 14 years of age (R) Fee: \$108.55 Benefit: 75% = \$81.45	85% = \$92.30	

DIAGNOSTIC RADIOLOGY		ANGIOGRAPHY	
60021	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of thorax - 10 or more data acquisition runs (R) (Anaes.) Fee: \$1,297.30 Benefit: 75% = \$973.00 85% = \$1,240.20		
60024	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$531.60 Benefit: 75% = \$398.70 85% = \$474.50		
60027	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$779.60 Benefit: 75% = \$584.70 85% = \$722.50		
60030	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,108.60 Benefit: 75% = \$831.45 85% = \$1,051.50		
60033	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of abdomen - 10 or more data acquisition runs (R) (Anaes.) Fee: \$1,297.30 Benefit: 75% = \$973.00 85% = \$1,240.20		
60036	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$531.60 Benefit: 75% = \$398.70 85% = \$474.50		
60039	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$779.60 Benefit: 75% = \$584.70 85% = \$722.50		
60042	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,108.60 Benefit: 75% = \$831.45 85% = \$1,051.50		
60045	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of upper limb or limbs - 10 or more data acquisition runs (R) (Anaes.) Fee: \$1,297.30 Benefit: 75% = \$973.00 85% = \$1,240.20		
60048	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$531.60 Benefit: 75% = \$398.70 85% = \$474.50		
60051	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$779.60 Benefit: 75% = \$584.70 85% = \$722.50		
60054	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,108.60 Benefit: 75% = \$831.45 85% = \$1,051.50		
60057	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.) Fee: \$1,297.30 Benefit: 75% = \$973.00 85% = \$1,240.20		
60060	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 1 to 3 data acquisition runs (R) (Anaes.) Fee: \$531.60 Benefit: 75% = \$398.70 85% = \$474.50		
60063	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 4 to 6 data acquisition runs (R) (Anaes.) Fee: \$779.60 Benefit: 75% = \$584.70 85% = \$722.50		
60066	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 7 to 9 data acquisition runs (R) (Anaes.) Fee: \$1,108.60 Benefit: 75% = \$831.45 85% = \$1,051.50		
60069	DIGITAL SUBTRACTION ANGIOGRAPHY, examination of aorta and lower limb or limbs - 10 or more data acquisition runs (R) (Anaes.) Fee: \$1,297.30 Benefit: 75% = \$973.00 85% = \$1,240.20		
60072	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 1 vessel (NR) (Anaes.) Fee: \$45.35 Benefit: 75% = \$34.05 85% = \$38.55		
60075	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 2 vessels (NR) (Anaes.) Fee: \$90.60 Benefit: 75% = \$67.95 85% = \$77.05		

DIAGNOSTIC RADIOLOGY		TOMOGRAPHY	
60078	SELECTIVE ARTERIOGRAPHY or SELECTIVE VENOGRAPHY by digital subtraction angiography technique - 3 or more vessels (NR) (Anaes.) Fee: \$135.95	Benefit: 75% = \$102.00	85% = \$115.60
SUBGROUP 14 - TOMOGRAPHY			
60100	TOMOGRAPHY OF ANY REGION (R) (Anaes.) Fee: \$57.30	Benefit: 75% = \$43.00	85% = \$48.75
SUBGROUP 15 - FLUOROSCOPIC EXAMINATION			
60500	FLUOROSCOPY, with general anaesthesia (not being a service associated with a radiographic examination) (R) (Anaes.) Fee: \$40.90	Benefit: 75% = \$30.70	85% = \$34.80
60503	FLUOROSCOPY, without general anaesthesia (not being a service associated with a radiographic examination)(R) Fee: \$28.05	Benefit: 75% = \$21.05	85% = \$23.85
60506	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting less than 1 hour, not being a service associated with a service to which another item in this Table applies (R) Fee: \$60.10	Benefit: 75% = \$45.10	85% = \$51.10
60509	FLUOROSCOPY using a mobile image intensifier, in conjunction with a surgical procedure lasting 1 hour or more, not being a service associated with a service to which another item in this Table applies (R) Fee: \$93.20	Benefit: 75% = \$69.90	85% = \$79.25
SUBGROUP 16 - PREPARATION FOR RADIOLOGICAL PROCEDURE			
60918	ARTERIOGRAPHY (peripheral) or PHLEBOGRAPHY 1 vessel, when used in association with a service to which items 59903 , 59912 , 59925 , 59970 , 59971 , 59972 , 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes.) Fee: \$49.65	Benefit: 75% = \$37.25	85% = \$42.25
60927	SELECTIVE ARTERIOGRAM or PHLEBOGRAM, when used in association with a service to which items 59903 , 59912 , 59925 , 59970 , 59971 , 59972 , 59973 or 59974 applies, not being a service associated with a service to which items 60000 to 60078 inclusive apply (NR) (Anaes.) Fee: \$40.05	Benefit: 75% = \$30.05	85% = \$34.05
SUBGROUP 17 - INTERVENTIONAL TECHNIQUES			
61109	FLUOROSCOPY in an ANGIOGRAPHY SUITE with image intensification, in conjunction with a surgical procedure, using interventional techniques, not being a service associated with a service to which another item in this Table applies (R) Fee: \$244.05	Benefit: 75% = \$183.05	85% = \$207.45

GROUP I4 - NUCLEAR MEDICINE IMAGING	
	<p>NOTE <i>Benefits for a nuclear medicine scanning service are only payable when the preliminary examination of the patient, estimation and administration of the dosage and the performance of the scan, are undertaken by a medical specialist, or on behalf of the medical specialist in the specialist's presence, and the compilation of the report is undertaken by the medical specialist. Additional benefits will only be attracted for a specialist or consultant physician attendance under Category 1 of the Schedule where there is a request for a full medical examination accompanied by a letter or note of referral.</i></p>
+ 61302	<p>SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) Fee: \$407.05 Benefit: 75% = \$305.30 85% = \$349.95</p>
+ 61303	<p>SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$512.65 Benefit: 75% = \$384.50 85% = \$455.55</p>
+ 61306	<p>COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) Fee: \$643.60 Benefit: 75% = \$482.70 85% = \$586.50</p>
+ 61307	<p>COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$757.10 Benefit: 75% = \$567.85 85% = \$700.00</p>
+ 61310	<p>MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) Fee: \$333.05 Benefit: 75% = \$249.80 85% = \$283.10</p>
+ 61313	<p>GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) Fee: \$275.10 Benefit: 75% = \$206.35 85% = \$233.85</p>
+ 61314	<p>GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) Fee: \$380.90 Benefit: 75% = \$285.70 85% = \$323.80</p>
+ 61316	<p>GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) Fee: \$345.65 Benefit: 75% = \$259.25 85% = \$293.85</p>
+ 61317	<p>GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) Fee: \$446.50 Benefit: 75% = \$334.90 85% = \$389.40</p>
+ 61320	<p>CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) Fee: \$207.60 Benefit: 75% = \$155.70 85% = \$176.50</p>
+ 61328	<p>LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) Fee: \$206.45 Benefit: 75% = \$154.85 85% = \$175.50</p>
+ 61340	<p>LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) Fee: \$229.45 Benefit: 75% = \$172.10 85% = \$195.05</p>
+ 61348	<p>LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) Fee: \$402.05 Benefit: 75% = \$301.55 85% = \$344.95</p>
+ 61352	<p>LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) Fee: \$235.20 Benefit: 75% = \$176.40 85% = \$199.95</p>
+ 61353	<p>LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$350.55 Benefit: 75% = \$262.95 85% = \$298.00</p>

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
+ 61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) Fee: \$356.20	Benefit: 75% = \$267.15	85% = \$302.80
+ 61360	HEPATOBIILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) Fee: \$365.75	Benefit: 75% = \$274.35	85% = \$310.90
+ 61361	HEPATOBIILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) Fee: \$418.45	Benefit: 75% = \$313.85	85% = \$361.35
+ 61364	BOWEL HAEMORRHAGE STUDY (R) Fee: \$450.65	Benefit: 75% = \$338.00	85% = \$393.55
+ 61368	MECKEL'S DIVERTICULUM STUDY (R) Fee: \$202.30	Benefit: 75% = \$151.75	85% = \$172.00
+ 61369	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (Ministerial Determination)(R) Fee: \$1,827.95	Benefit: 75% = \$1,371.00	85% = \$1,770.85
+ 61372	SALIVARY STUDY (R) Fee: \$202.30	Benefit: 75% = \$151.75	85% = \$172.00
+ 61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) Fee: \$444.10	Benefit: 75% = \$333.10	85% = \$387.00
+ 61376	OESOPHAGEAL CLEARANCE STUDY (R) Fee: \$130.00	Benefit: 75% = \$97.50	85% = \$110.50
+ 61381	GASTRIC EMPTYING STUDY, using single tracer (R) Fee: \$520.85	Benefit: 75% = \$390.65	85% = \$463.75
+ 61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) Fee: \$566.75	Benefit: 75% = \$425.10	85% = \$509.65
+ 61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) Fee: \$623.65	Benefit: 75% = \$467.75	85% = \$566.55
+ 61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) Fee: \$301.50	Benefit: 75% = \$226.15	85% = \$256.30
+ 61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) Fee: \$390.65	Benefit: 75% = \$293.00	85% = \$333.55
+ 61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) Fee: \$336.05	Benefit: 75% = \$252.05	85% = \$285.65
+ 61390	RENAL STUDY with diuretic administration following a baseline study (R) Fee: \$371.80	Benefit: 75% = \$278.85	85% = \$316.20
+ 61393	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) Fee: \$549.10	Benefit: 75% = \$411.85	85% = \$492.00
+ 61397	CYSTOURETEROGRAM (R) Fee: \$223.85	Benefit: 75% = \$167.90	85% = \$190.30
+ 61401	TESTICULAR STUDY (R) Fee: \$147.15	Benefit: 75% = \$110.40	85% = \$125.10
+ 61402	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) Fee: \$548.70	Benefit: 75% = \$411.55	85% = \$491.60

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
+ 61405	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) Fee: \$313.75 Benefit: 75% = \$235.35 85% = \$266.70		
+ 61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) Fee: \$792.10 Benefit: 75% = \$594.10 85% = \$735.00		
+ 61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) Fee: \$204.90 Benefit: 75% = \$153.70 85% = \$174.20		
+ 61417	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) Fee: \$107.75 Benefit: 75% = \$80.85 85% = \$91.60		
+ 61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Fee: \$435.10 Benefit: 75% = \$326.35 85% = \$378.00		
+ 61425	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) Fee: \$544.75 Benefit: 75% = \$408.60 85% = \$487.65		
+ 61426	WHOLE BODY STUDY using iodine (R) Fee: \$503.10 Benefit: 75% = \$377.35 85% = \$446.00		
+ 61429	WHOLE BODY STUDY using gallium (R) Fee: \$492.40 Benefit: 75% = \$369.30 85% = \$435.30		
+ 61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) Fee: \$598.00 Benefit: 75% = \$448.50 85% = \$540.90		
+ 61433	WHOLE BODY STUDY using cells labelled with technetium (R) Fee: \$450.65 Benefit: 75% = \$338.00 85% = \$393.55		
+ 61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) Fee: \$558.05 Benefit: 75% = \$418.55 85% = \$500.95		
+ 61437	WHOLE BODY STUDY using thallium (R) Fee: \$492.20 Benefit: 75% = \$369.15 85% = \$435.10		
+ 61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) Fee: \$610.30 Benefit: 75% = \$457.75 85% = \$553.20		
+ 61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) Fee: \$444.10 Benefit: 75% = \$333.10 85% = \$387.00		
+ 61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) Fee: \$682.25 Benefit: 75% = \$511.70 85% = \$625.15		
+ 61445	BONE MARROW STUDY - localised using technetium labelled agent (R) Fee: \$260.10 Benefit: 75% = \$195.10 85% = \$221.10		
+ 61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) Fee: \$302.50 Benefit: 75% = \$226.90 85% = \$257.15		
+ 61449	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) Fee: \$413.75 Benefit: 75% = \$310.35 85% = \$356.65		
+ 61450	LOCALISED STUDY using gallium (R) Fee: \$360.50 Benefit: 75% = \$270.40 85% = \$306.45		
+ 61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) Fee: \$466.75 Benefit: 75% = \$350.10 85% = \$409.65		

NUCLEAR MEDICINE IMAGING		NUCLEAR MEDICINE IMAGING	
+ 61454	LOCALISED STUDY using cells labelled with technetium (R) Fee: \$315.65	Benefit: 75% = \$236.75	85% = \$268.35
+ 61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) Fee: \$426.65	Benefit: 75% = \$320.00	85% = \$369.55
+ 61458	LOCALISED STUDY using thallium (R) Fee: \$359.95	Benefit: 75% = \$270.00	85% = \$306.00
+ 61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) Fee: \$478.70	Benefit: 75% = \$359.05	85% = \$421.60
+ 61462	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364 , 61426 , 61429 , 61430 , 61442 , 61450 , 61453 or 61469 , where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) Derived Fee: The fee for the nuclear medicine investigation plus an amount of \$118.15		
+ 61465	VENOGRAPHY (R) Fee: \$240.75	Benefit: 75% = \$180.60	85% = \$204.65
+ 61469	LYMPHOSCINTIGRAPHY (R) Fee: \$315.65	Benefit: 75% = \$236.75	85% = \$268.35
+ 61473	THYROID STUDY including uptake measurement when undertaken (R) Fee: \$159.05	Benefit: 75% = \$119.30	85% = \$135.20
+ 61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) Fee: \$350.80	Benefit: 75% = \$263.10	85% = \$298.20
+ 61484	ADRENAL STUDY, with imaging on 2 or more separate occasions (R) Fee: \$798.80	Benefit: 75% = \$599.10	85% = \$741.70
+ 61485	ADRENAL STUDY, with imaging on 2 or more occasions and renal localisation and single photon emission tomography when undertaken (R) Fee: \$906.15	Benefit: 75% = \$679.65	85% = \$849.05
+ 61495	TEAR DUCT STUDY (R) Fee: \$202.30	Benefit: 75% = \$151.75	85% = \$172.00
+ 61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Vein shunt study (R) Fee: \$229.45	Benefit: 75% = \$172.10	85% = \$195.05

GROUP I5 - MAGNETIC RESONANCE IMAGING			
SUBGROUP 1 - SCAN OF HEAD - FOR THE EXCLUSION OF SPECIFIED CONDITONS			
<p>NOTE: Benefits are payable for each service included in Subgroup 1 on one occasion only in a 12 month period</p> <p>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:</p>			
63000	- tumour of the brain or meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63003	- skull base or orbital tumour (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63006	- acoustic neuroma (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63009	- pituitary tumour (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63012	- inflammation of brain or meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63015	- toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63018	- demyelinating disease of the brain (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63021	- congenital malformation of brain or meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63024	- venous sinus thrombosis (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
SUBGROUP 2 - SCAN OF HEAD AND CERVICAL SPINE - FOR THE EXCLUSION OF SPECIFIED CONDITIONS			
<p>NOTE: Benefits are payable for each service included by Subgroup 2 on one occasion only in a 12 month period</p> <p>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:</p>			
63050	- tumour of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63053	- inflammation of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63056	- demyelinating disease of the central nervous system (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63059	- congenital malformation of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63062	- syrinx (congenital or acquired) (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90

SUBGROUP 3 - SCAN OF HEAD - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included 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) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63103	- skull base or orbital tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63106	- acoustic neuroma (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63109	- pituitary tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63112	- inflammation of the brain or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63115	- toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63118	- demyelinating disease of the brain (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63121	- congenital malformation of the brain or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63124	- head trauma (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63127	- epilepsy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63130	- stroke (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63133	- venous sinus thrombosis (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90

SUBGROUP 4 - SCAN OF HEAD AND CERVICAL SPINE - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included 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:

63150	- tumour of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63153	- inflammation of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63156	- demyelinating disease of the central nervous system (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90
63159	- congenital malformation of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90

MAGNETIC RESONANCE IMAGING		MRI
63162	- syrx (congenital or acquired) (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 5 - SCAN OF HEAD - FOR MONITORING OF SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included 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:		
63200	- acoustic neuroma (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63203	- pituitary tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63206	- demyelinating disease of the brain (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63209	- congenital malformation of brain or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63212	- head trauma (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63215	- epilepsy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63218	- stroke (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63221	- toxic or metabolic or ischaemic encephalopathy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 6 - SCAN OF HEAD AND CERVICAL SPINE - FOR MONITORING OF SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included 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:		
63250	- demyelinating disease of the central nervous system (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63253	- congenital malformation of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63256	-syrinx (congenital or acquired) (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
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:		
63270	- tumour of the brain or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	

MAGNETIC RESONANCE IMAGING		MRI
63273	- skull base or orbital tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63276	- inflammation of brain or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63279	- venous sinus thrombosis (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
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:		
63290	- tumour of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63293	- inflammation of the central nervous system or meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 9 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR THE EXCLUSION OF A SPECIFIED CONDITION		
NOTE: Benefits are payable for each service included 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:		
63300	- infection (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63303	- tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63306	- demyelinating disease (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63309	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63312	- myelopathy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63315	- syrinx (congenital or acquired) (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 10 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR THE EXCLUSION OF SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included 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:		
63350	- infection (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63353	- tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	

MAGNETIC RESONANCE IMAGING		MRI
63356	- demyelinating disease (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63359	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63362	- myelopathy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63365	- syrinx (congenital or acquired) (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 11 - SCAN OF SPINE - ONE REGION OR TWO CONTIGUOUS REGIONS - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included 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:		
63400	- infection (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63403	- tumour (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63406	- demyelinating disease (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63409	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63412	- myelopathy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63415	- syrinx (congenital or acquired) (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63418	- cervical radiculopathy (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63421	- sciatica (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63424	- spinal canal stenosis (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63427	- previous spinal surgery (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63430	- trauma (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	

MAGNETIC RESONANCE IMAGING				MRI
63512	- cervical radiculopathy (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63515	- sciatica (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63518	- spinal canal stenosis (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63521	- previous spinal surgery (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63524	- trauma (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
SUBGROUP 14 - SCAN OF SPINE - THREE CONTIGUOUS OR TWO NON CONTIGUOUS REGIONS - FOR MONITORING OF SPECIFIED CONDITIONS				
NOTE: Benefits are payable for each service included 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:				
63550	- demyelinating disease (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63553	- congenital malformation of the spinal cord or the cauda equina or the meninges (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63556	- myelopathy (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63559	- syrinx (congenital or acquired) (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63562	- cervical radiculopathy (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63565	- sciatica (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63568	- spinal canal stenosis (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63571	- previous spinal surgery (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63574	- trauma (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
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:				
63580	- infection (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	
63583	- tumour (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90	

SUBGROUP 18 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 18 on one occasion only in a 12 month period, for one service per item per episode.

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:

63650 - tumour arising in bone or other connective tissue (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63653 - infection arising in bone or other connective tissue (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63656 - osteonecrosis (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63659 - derangement of hip or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63662 - derangement of shoulder or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63665 - derangement of knee or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63668 - derangement of ankle or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63671 - derangement of temporomandibular joint or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63674 - derangement of wrist or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63677 - derangement of elbow or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63680 - post-inflammatory or post-traumatic physal fusion in a person under 16 years of age (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

SUBGROUP 19 - SCAN OF MUSCULOSKELETAL SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for each service included by Subgroup 19 on one occasion only in a 12 month period, for one service per item per episode.

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:

63700 - derangement of hip or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63703 - derangement of shoulder or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63706 - derangement of knee or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63709 - derangement of ankle or its supporting structures (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

MAGNETIC RESONANCE IMAGING		MRI
SUBGROUP 23 - SCAN OF CARDIOVASCULAR SYSTEM - FOR MONITORING OF SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included 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) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63803	- tumour of the heart or a great vessel (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63806	- abnormality of the thoracic aorta (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 24 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR THE EXCLUSION OF OR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS		
NOTE: Benefits are payable for each service included 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) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63853	- carotid or vertebral artery dissection (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63856	- intracranial aneurysm (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63859	- intracranial arteriovenous malformation (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63862	- venous sinus thrombosis (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63865	- vascular abnormality in a patient with a previous anaphylactic reaction to an iodinated contrast medium (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
63868	- obstruction of the superior vena cava, inferior vena cava or a major pelvic vein (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	
SUBGROUP 25 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS		
NOTE: Benefits are payable for each service included 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:		
63870	- the vasculature of limbs prior to limb or digit transfer surgery in congenital limb deficiency syndrome (R) (Anaes.) Fee: \$475.00 Benefit: 75% = \$356.25 85% = \$417.90	

SUBGROUP 26 - MAGNETIC RESONANCE ANGIOGRAPHY - SCAN OF CARDIOVASCULAR SYSTEM - FOR MONITORING 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:

63880 - carotid or vertebral artery dissection (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63883 - venous sinus thrombosis (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

SUBGROUP 27 - SCAN OF BODY - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS

NOTE: Benefits are payable for each service included 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:

63900 - pelvic or abdominal mass (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63903 - mediastinal mass (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63906 - congenital uterine or anorectal abnormality (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

63909 - Gaucher disease (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

SUBGROUP 28 - SCAN OF BODY - FOR FURTHER INVESTIGATION OF SPECIFIED CONDITIONS

NOTE: Benefits are payable for the each service included 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:

63920 - adrenal mass in a patient with a malignancy which is otherwise resectable (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

SUBGROUP 29 - SCAN OF BODY - FOR MONITORING OF SPECIFIED CONDITIONS - PERSON UNDER THE AGE OF 16 YEARS

NOTE: Benefits are payable for the each service included 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:

63930 - congenital uterine or anorectal abnormality (R) (Anaes.)
Fee: \$475.00 **Benefit:** 75% = \$356.25 85% = \$417.90

**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 - <u>scan of the body of a person under the age of 16 years</u> for monitoring of:		
63940	- mediastinal mass (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63943	- pelvic or abdominal mass (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90
63946	- Gaucher disease (R) (Anaes.) Fee: \$475.00	Benefit: 75% = \$356.25	85% = \$417.90

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PATHOLOGY SERVICES

CATEGORY 6

PLEASE NOTE:

The information contained in this Category relates specifically to the Pathology Services Arrangements under Medicare. More comprehensive information on the Medicare Benefits Schedule book and the Medicare Arrangements are contained in the INTRODUCTION and the GENERAL EXPLANATORY NOTES to this book, which should be read in conjunction with this Category.



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CATEGORY 6 - PATHOLOGY SERVICES

OUTLINE OF ARRANGEMENTS

PA. PATHOLOGY SERVICES IN RELATION TO MEDICARE BENEFITS

PA.1 Basic Requirements

PA.1.1 *Determination of Necessity of Service*

The treating practitioner must determine that the pathology service is necessary.

PA.1.2 *Request for Service*

The service may only be provided:

- (i) in response to a request from the treating practitioner or from another Approved Pathology Practitioner and the request must be in writing (or, if oral, confirmed in writing within fourteen days); or
- (ii) if determined to be necessary by an Approved Pathology Practitioner who is treating the patient.

PA.1.3 *Provision of Service*

The following conditions relate to provision of services:

- (i) the service has to be provided by or on behalf of an Approved Pathology Practitioner;
- (ii) the service has to be provided in a pathology laboratory accredited for that kind of service;
- (iii) the proprietor of the laboratory where the service is performed must be an Approved Pathology Authority;
- (iv) the Approved Pathology Practitioner providing the service must either be the proprietor of the laboratory or party to an agreement, either by way of contract of employment or otherwise, with the proprietor of the laboratory in which the service is provided; and
- (v) no benefit will be payable for services provided by an Approved Pathology Practitioner on behalf of an Approved Pathology Authority if they are not performed in the laboratories of that particular Approved Pathology Authority.

PA.1.4 *Therapeutic Goods Act 1989*

For any service listed in the MBS to be eligible for a Medicare rebate, the service must be rendered in accordance with the provisions of the relevant Commonwealth and State and Territory laws. Approved Pathology Practitioners have the responsibility to ensure that the supply of medicines or medical devices used in the provision of pathology services is strictly in accordance with the provisions of the *Therapeutic Goods Act 1989*.

PA.2 Exceptions to Basic Requirements

PA.2.1 *Prescribed Pathology Services*

A prescribed pathology service is a service included in Group P9 of the Pathology Services Table. Group P9 contains 11 services which may be performed by a medical practitioner in his or her own surgery on his or her own patients.

Additionally, benefit is payable only where the service is determined to be necessary by the medical practitioner rendering the service, or is in response to a request by a member of a group of practitioners to which that practitioner belongs (see PO.2 for the definition of a "group of practitioners").

PA.2.2 *Services Where Request Not Required*

A written request is not required for -

- (i) a prescribed pathology service rendered by or on behalf of a medical practitioner upon his or her own patients;

- (ii) a pathologist-determinable service. (A pathologist-determinable service is a pathology service determined to be necessary by an Approved Pathology Practitioner in respect of a person who is the patient of that Approved Pathology Practitioner and which is rendered by or on behalf of that Approved Pathology Practitioner. Further information on additional pathology tests not covered by a request is provided at PB.3.)

PA.3 Circumstances Where Medicare Benefits Not Attracted

PA.3.1 Services Rendered by Disqualified Practitioner

Medicare benefits are not payable for pathology services if at the time the service is rendered, the person, by or on whose behalf the service is rendered, is a person in relation to whom a determination is in force in relation to that class of services. That is, where an Approved Pathology Practitioner has breached an undertaking, and a determination has been made that Medicare benefits should not be paid during a specified period (of up to five years) in respect of specified pathology services rendered by the practitioner.

Note: An Approved Pathology Practitioner may be disqualified for reasons other than a breach of undertaking.

PA.3.2 Certain Pathology Tests Do Not Attract Medicare Benefits

Certain tests of public health significance do not qualify for payment of Medicare benefits. Examples of services in this category are:

- . examination by animal inoculation;
- . Guthrie test for phenylketonuria;
- . neonatal screening for hypothyroidism (T4/TSH estimation);
- . neonatal screening for Cystic Fibrosis;
- . neonatal screening for Galactosemia;
- . pathology services used with the intention of monitoring the performance enhancing effects of any substance;
- . pathology tests carried out on specimens collected from persons occupationally exposed to sexual transmission of disease where the purpose of the collection of specimens is for testing in accordance with conditions determined by the health authority of the State or Territory in which the service is performed; and
- . the detection of the presence of human immunodeficiency virus (HIV) except quantitation as specified in items [69378](#), [69381](#) and [69382](#).

In addition to the above, certain other tests do not qualify for payment of Medicare benefits. These include:

- . cytotoxic food testing;
- . pathology services performed for the purposes of tissue audit;
- . pathology services performed for the purposes of control estimation, repeat tests (eg. for confirmation of earlier tests on the same specimen, etc);
- . preparation of autogenous vaccines;
- . tissue banking and preparation procedures;
- . pathology services which are performed routinely in association with the termination of pregnancy without there being any indication for the necessity of the services. However, benefits will be paid for the following pathology tests: item [65060](#) - haemoglobin estimation;
 - item [65090](#) - blood grouping ABO and Rh (D antigen);
 - item [65096](#) - examination of serum for Rh and other blood group antibodies; and
- . pathology services performed on stillborn babies or cadavers.

PB. REQUESTS

PB.1 Responsibilities of Treating/Requesting Practitioners

PB.1.1 Form of Request

A treating practitioner may request a pathology service either orally or in writing but oral requests must be confirmed in writing within fourteen days from the day when the oral request was made.

Pathology request forms and combined pathology request/offer to assign forms which are prepared by the pathologists and distributed to requesting practitioners must be approved by the Health Insurance Commission (see PB.2). Written pathology requests from treating practitioners that are not on a form prepared and distributed by a pathologist do not need to be approved. However, all written requests for pathology services should contain the following particulars:

- (i) the individual pathology services, or recognised groups of pathology tests to be rendered (see section PQ of these notes for the list of acceptable terms and abbreviations). The description must be sufficient to enable the item in which the service is specified to be identified;
- (ii) the requesting practitioner's signature and date of request;
- (iii) the surname, initials of given names, practice address and provider number of the requesting practitioner;
- (iv) the patient's name and address;
- (v) details of the hospital status of the patient, as follows (for benefit rate assessment). That is, whether the patient was or will be, at the time of the service and when the specimen is obtained:
 - (a) a private patient in a private hospital, or approved day hospital facility;
 - (b) a private patient in a recognised hospital;
 - (c) a Medicare (public) patient in a recognised hospital;
 - (d) an outpatient of a recognised hospital;
- (vi) details of the person to whom the request is directed. A pathology request can be directed to an Approved Pathology Practitioner or an Approved Pathology Authority. If the request is directed to an Approved Pathology Authority, the form must show the full name and address of the Approved Pathology Authority. If the request is directed to an Approved Pathology Practitioner, the form must show the surname, initials or given names and place of practice of the Approved Pathology Practitioner to whom the request is addressed.

PB.1.2 *Offence Not to Confirm an Oral Request*

A requesting practitioner who, without reasonable excuse, does not confirm in writing an oral request within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding \$1000, and the request is deemed never to have been made.

PB.2 Responsibilities of Approved Pathology Practitioners

PB.2.1 *Form of Request*

There is no official "request in writing" form, and the requesting practitioner's own stationery, or pre-printed forms supplied by Approved Pathology Practitioners/Authorities are acceptable, provided there are no check lists or "tick-a-box" lists of individual tests or groups of pathology services on the forms. However, pre-printed request forms issued by Approved Pathology Practitioners/Authorities for use by requesting practitioners must be approved by the Health Insurance Commission. Forms submitted for approval should be accompanied by other information or documentation such as that contained in notes for guidance, cover sheets, etc., provided to requesting practitioners.

PB.2.2 *Offence to Provide Unapproved Request Forms*

An Approved Pathology Practitioner or Approved Pathology Authority who, without reasonable excuse, provides (directly or indirectly) to practitioners request forms which are not approved by the Health Insurance Commission, is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding \$1000.

PB.2.3 *Request to Approved Pathology Authority*

It is acceptable for a request to be made to an Approved Pathology Authority who is the proprietor or one of the proprietors of a laboratory instead of making the request to the Approved Pathology Practitioner who renders the service or on whose behalf the service is rendered.

PB.2.4 *Holding, Retention, Recording and Production of Request Forms*

Approved Pathology Practitioners must hold a request in writing for all services requested by any other practitioner before billing patients.

An Approved Pathology Practitioner is required to retain written requests/confirmation of requests for pathology services for 18 months from the day when the service was rendered. This also applies to requests which an Approved Pathology Practitioner receives of which only some tests are referred to another Approved Pathology Practitioner (the first Approved

Pathology Practitioner would retain the request for 18 months). If all tests were referred, the second pathologist would retain the original request.

If the written request or written confirmation has been recorded on film or other magnetic medium approved by the Minister for Health and Ageing, for the purposes of storage and subsequent retrieval, the record so made shall be deemed to be a retention of the request or confirmation. The production or reproduction of such a record shall be deemed to be a production of the written request or written confirmation.

An Approved Pathology Practitioner is required to produce, on request from an officer of the Health Insurance Commission, no later than the end of the day following the request from the officer, a written request or written confirmation retained pursuant to the above paragraphs. The officer is authorised to make and retain copies of or take and retain extracts from written requests or written confirmations.

PB.2.5 Offences in Relation to Retaining and Producing Request Forms

The following offences are punishable upon conviction by a fine not exceeding \$1000:

- (i) an Approved Pathology Practitioner who, without reasonable excuse, does not keep request forms for 18 months;
- (ii) an Approved Pathology Practitioner who, without reasonable excuse, does not produce a request form to an officer of the Health Insurance Commission before the end of the day following the day of the officer's request.

PB.2.6 Referral From An Approved Pathology Practitioner To Another Approved Pathology Practitioner

Where an Approved Pathology Practitioner refers some or all services requested to another Approved Pathology Practitioner not associated with the same Approved Pathology Authority the following apply:

- (i) where all the services are referred, the first Approved Pathology Practitioner should forward the original request to the second Approved Pathology Practitioner, and the document bearing the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;
- (ii) where some of the services which are listed in different items in the Schedule are referred, the first Approved Pathology Practitioner must issue his/her own request in writing listing the tests to be performed, and when necessary, forward a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can direct-bill Medicare;

in addition to the details of the first Approved Pathology Practitioner, the second Approved Pathology Practitioner must show on the account/receipt/assignment form:

- (a) name and provider number of the original requesting practitioner; and
- (b) date of original request;
- (iii) under the item coning rules (which limit benefits for multiple services) only one Medicare benefit is payable for services included in coned items except for estimations covered by [rule 6](#) entitled "designated pathology services". The exemption allows payment of more than one Medicare benefit where various components of the one item number from the same request e.g. drug assays (item [66611](#)) are performed by two Approved Pathology Authorities.

Although the provisions concerning designated pathology services in [rule 6](#) permit similar services (e.g. hormone estimations) to be performed by 2 or more laboratories, with different Approved Pathology Authorities, the sum of the Medicare benefit payable for services provided by the laboratories concerned will not exceed the maximum amount payable under the item coning rules when a single laboratory performs all the estimations.

Notes:

- (i) the patient should be billed by each Approved Pathology Practitioner only for those services rendered by or on his/her behalf;
- (ii) photocopies of requests are not acceptable;

- (iii) in the case of "designated pathology services" (i.e. items [66620](#), [66713](#), [66737](#) and [69402](#) only)

a patient episode initiation fee (PEI) is payable for the services provided by the laboratory which receives the original request and performs one or more of the estimations. However, no PEI is payable for services provided by the other laboratory which performs the remainder of the estimations. A "specimen referred fee" is payable instead. One Approved Pathology Practitioner cannot claim both a PEI and a "specimen referred fee" in relation to the same patient episode.

PB.2.7 Offence Not To Confirm An Oral Request

An Approved Pathology Practitioner who, without reasonable excuse, does not confirm in writing an oral request to another Approved Pathology Practitioner within fourteen days of making the oral request is guilty of an offence under the *Health Insurance Act 1973* punishable, upon conviction, by a fine not exceeding \$1000, and the request is deemed never to have been made.

PB.3 Pathology Tests Not Covered by Request

An Approved Pathology Practitioner, who has been requested to perform one or more pathology services, may consider it necessary, in the interest of the patient, that additional tests to those requested be carried out. The Approved Pathology Practitioner must discuss this need with the requesting practitioner, and if the requesting practitioner determines that additional tests are necessary, the Approved Pathology Practitioner must arrange with the requesting practitioner to forward an amended or second request for those services. The account will then be issued in the ordinary way and the additional services will attract benefits providing the Approved Pathology Practitioner is a recognised specialist pathologist.

PC. DETAILS REQUIRED ON ACCOUNTS, RECEIPTS OR ASSIGNMENT FORMS

PC.1 General

Medicare benefit is not payable in respect of a pathology service unless specified details are provided, by the practitioner rendering the service, on his or her account, receipt or assignment form.

PC.2 Approved Pathology Practitioners

In addition to holding a request in writing from the treating medical or dental practitioner or from another Approved Pathology Practitioner, the following additional details must be recorded on the account, receipt or assignment form of the Approved Pathology Practitioner providing the service:

- (i) the surname and initials of the Approved Pathology Practitioner who performed the service and either his/her practice address or the provider number for the address;
- (ii) the name of the person to whom the service was rendered;
- (iii) the date on which the service was rendered;
- (iv) the name of the requesting practitioner;
- (v) the date on which the request was made;
- (vi) the requesting practitioner's provider number;
- (vii) a description of the pathology service in words which are derived from the item description in the Schedule and are of sufficient detail to identify the specific test in the Schedule that was rendered. Instead of such a full description, the abbreviations contained in the index and the group abbreviations listed at PQ.4 are acceptable alternatives (see PQ.1);
- (viii) where the Approved Pathology Practitioner determines or provides a pathology service on his/her own patient, the account must be endorsed "sd"; and
- (ix) provide collection centre identification number if the specimen was collected in a licensed collection centre (or approved pathology collection centre).

Where some services are referred from one Approved Pathology Practitioner to another Approved Pathology Practitioner, the request details to be shown on the second Approved Pathology Practitioner's account, receipt or assignment form must be identical to those of the original requesting practitioner including the date of request.

PC.3 Prescribed Pathology Services

For Prescribed Pathology Services (that is, pathology items in Group P9) the medical practitioner who renders the service must ensure his or her account, receipt or assignment form includes his or her name, address or provider number, the date of the service, and a description to clearly identify the service in the Schedule that was rendered.

If the service was determined necessary by another medical practitioner who is a member of the same group practice as the practitioner who rendered the service, the name of the requesting practitioner, sufficient to identify the practitioner from other practitioners in the same group practice with the same surname, must also be included together with the date on which the request was made.

PD. MULTIPLE SERVICES RULE

PD.1 Description of Rule

The term "Multiple Services Rule" (Rule 3 of the Pathology Services Table) describes an arrangement which places limits on the benefits payable for items in the Pathology Services Table depending on the range of services performed during a single patient episode. A patient episode is defined in PO.4 of these notes.

PD.2 Exemptions

Under Rule 4 of the Pathology Services Table, exemptions to the multiple services rule have been granted for certain specified tests. In some circumstances tests which are repeated up to 4 times over a 24 hour period, or tests which are requested up to 6 times on a single request form and are performed within 6 months of the date of request may be eligible for separate Medicare benefits. The services to which the exemptions apply are listed under Rule 4.(1 and 2) and cover seriously or chronically ill patients who require particular tests under specified circumstances. In order to claim the exemptions, accounts should be endorsed "Rule 3 Exemption".

Where a practitioner seeks an exemption to the multiple services rule for a patient whose condition requires a series of pathology investigations at various times throughout any one day or over a longer period of time, and the services required are not exempted under Rule 4, an application for exemption can be made which is endorsed "S4B(3)". Some factors that the delegate of the Minister may take into consideration in approving an exemption are: the patient is seriously ill; there are distinct and separate collections and performances of tests; and the services involve substantial additional expenses for the Approved Pathology Practitioner. These, and other clinical details, should be supplied by the practitioner when seeking an S4B(3) exemption.

If Rule 3 exemptions are endorsed "S4B(3)", claim assessment could take longer as all S4B(3) claims are passed to the delegate for assessment. S4B(3) covers all exemptions to the multiple services rule but, where applicable, specific "Rule 3 exemption" endorsements will speed up the payment of claims. Rule 3 and S4B(3) exemptions cannot be used to overcome time based restrictions within items e.g. "... each test to a maximum of 4 tests in a 12 month period".

PE. EPISODE CONE

PE.1 Description of Rule 18

The term "Episode Cone" describes an arrangement under which Medicare benefits payable in a patient episode for a set of pathology services, containing more than three items, ordered by a general practitioner for a non-hospitalised patient, will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. Further information on the episode coning arrangements is provided in [PO.5](#) of these notes.

PE.2 Exemptions

Some items are not included in the count of the items performed when applying episode coning. The items which have been exempted from the cone include all the items in Groups [P10](#) and [P11](#), the Pap smear testing items ([73053](#) and [73055](#)) and the designated pathology services items ([66620](#), [66713](#), [66737](#) and [69402](#)).

PF. SCHEDULE FEES

PF.1 Single Level Fees

A single level Schedule fee as opposed to the previous SP and OP fee levels was introduced from 1 February 1992. The Schedule fee was set at 70% of the previous SP fee for all services except for a cytology item, a histopathology item and three high volume test items.

PF.2 Patient Episode Initiation Fees (PEIs)

Items in Groups [P10](#) and [P11](#) of the Pathology Services Table are only applicable to services performed:

- (i) by or on behalf of an Approved Pathology Practitioner who is a recognised specialist pathologist; and
- (ii) in private practice.

Accordingly, these fees are not payable for pathology services rendered by an Approved Pathology Practitioner, being a specialist pathologist when requested for a:

- (i) privately referred out-patient of a recognised hospital;
- (ii) private in-patient in a recognised hospital; or where
 - (a) any pathology equipment of a recognised hospital, or a laboratory included in a prescribed class of laboratories, is used; or
 - (b) any member of the staff of a recognised hospital, or a laboratory included in a prescribed class of laboratories, participates in the provision of the service in the course of his/her employment with that hospital or laboratory.

The patient episode initiation fees (PEIs) will be applicable on an episodic basis i.e. a claim may be made for the provision of pathology services requested by a practitioner in respect of one individual on the same day. For example, if a practitioner orders three pathology tests for a person on the one day, Medicare benefits will be payable for each of those tests but only one PEI will be applicable.

This Rule applies even when the treating practitioner has requested pathology tests from two or more Approved Pathology Practitioners. Thus a PEI will only be paid for the first account submitted unless an exemption listed in Rule 4 or 15.(7) applies or an exemption has been granted under "S4B(3)".

Under Rule 15.(7) two PEIs are payable in relation to the same patient episode where a referring practitioner refers two different specimens to two different Approved Pathology Authorities in the following circumstances:

- . a tissue pathology specimen and any other non-tissue pathology specimen; or
- . a cytopathology specimen and any other non-cytopathology specimen.

Rule 15.(8) also provides that only one PEI will be paid for the collection of specimens from a patient on one day in or by a single Approved Pathology Authority.

The patient episode initiation fees are two-tiered.

A higher fee will be payable for specimens collected in an approved collection centre, private hospital or day hospital facility where the patient is an in-patient. The specimen must be collected by an employee of the proprietor of the laboratory in which the pathology service will be rendered, or an Approved Pathology Practitioner associated with that laboratory.

A lower fee will be payable for specimens collected by the patient himself or herself or specimens collected by or on behalf of a treating practitioner.

PF.3 Patient Episode Initiation Fees for Certain Tissue Pathology and Cytology Items

Tissue Pathology items [72813](#), [72816](#), [72817](#), [72823](#), [72824](#), [72825](#), [72830](#) and [72836](#) and Cytology items [73053](#), [73055](#) and [73057](#) will be subject to a different patient episode initiation fee structure - items [73901](#) to [73905](#) refer.

PF.4 Hospital, Government etc Laboratories

The following laboratories have been prescribed for the purposes of payment of Medicare benefits as outlined in paragraphs PF.2 and PF.3:

- (i) laboratories operated by the Commonwealth (these include Commonwealth health laboratories operated by the Department of Health and Ageing as well as the laboratories operated by other Departments, e.g. the

Departments of Defence and Veterans' Affairs operate laboratories from which pathology services are provided);

- (ii) laboratories operated by a State Government or authority of a State (laboratories operated or associated with recognised hospitals are also included);
- (iii) laboratories operated by the Northern Territory and the Australian Capital Territory; and
- (iv) laboratories operated by Australian tertiary education institutions eg Universities.

PG. ASSIGNMENT OF MEDICARE BENEFITS

PG.1 Patient Assignment

In addition to the general arrangements relating to the assignment of benefits, as outlined at [paragraph 7](#) of the "General Explanatory Notes" in Section 1 of this book, it should be noted that, where the treating practitioner requests pathology services but the patient does not physically attend the Approved Pathology Practitioner, the patient may complete an assignment voucher at the time of the visit to the requesting doctor offering to assign benefits for the Approved Pathology Practitioner's services.

If an Approved Pathology Practitioner refers some of the tests requested by the treating practitioner to another Approved Pathology Authority, he/she should provide the second Approved Pathology Authority with a photocopy of the patient's assignment voucher so that the second Approved Pathology Authority can also direct-bill Medicare.

PG.2 Approved Pathology Practitioner Eligibility

If a practitioner requests an Approved Pathology Practitioner to perform a necessary pathology service, that Approved Pathology Practitioner must personally perform the service or have it performed on his/her behalf in order to be eligible to receive benefits by way of assignment. If, however, the first Approved Pathology Practitioner arranges for the service to be rendered by a second Approved Pathology Practitioner with the same Approved Pathology Authority, the second Approved Pathology Practitioner and not the first, is eligible to receive an assignment of the Medicare benefit for the service in question.

PH. ACCREDITED PATHOLOGY LABORATORIES

PH.1 Need For Accreditation

A pathology service will not attract Medicare benefits unless that service is provided in a pathology laboratory which is accredited for that kind of service. Details of the administration of the pathology laboratory accreditation arrangements are set out below.

PH.2 Applying For Accreditation

To become an Accredited Pathology Laboratory it is necessary to lodge a completed application form with the Manager, Pathology Section, Health Insurance Commission, PO Box 1001, TUGGERANONG ACT 2901. The prescribed fees for Approved Pathology Laboratories are:

- . \$2500 for Category GX labs
- . \$2000 for Category GY labs
- . \$1500 for Category B labs
- . \$ 750 for Category M & S labs.

It is necessary for an application for inspection be made to an approved inspection agency. The National Association of Testing Authorities (NATA) has been chosen to act on the Commonwealth's behalf as the primary inspection agency. The Royal Australian College of General Practitioners (RACGP) has also been appointed to inspect laboratories in Category M (general practitioner) in Victoria only.

The arrangements for laboratory categorisation changed on 1 January 2000. Information about the new laboratory categories and associated supervisory requirements can be found on the Department's internet site (<http://www.health.gov.au>). Alternatively, contact the Secretariat of the National Pathology Accreditation Advisory Council (see [PH.6](#)) on (02) 6289 4017 or email npaac@health.gov.au.

PH.3 Effective Period of Accreditation

Accreditation takes effect from the date of approval by the Minister for Health and Ageing. The Minister has no power to backdate an approval. Transitional accreditation may be given pending full accreditation. An application and fee are required annually.

PH.4 Assessment of Applications for Accreditation

The principles of accreditation for pathology laboratories as determined by the Minister are used to assess applications for accreditation. These principles also require pathology laboratories to address National Pathology Accreditation Advisory Council standards. Copies of the principles and standards are available from the Secretariat, National Pathology Accreditation Advisory Council (see PH.6) on (02) 6289 4017 or email npaac@health.gov.au.

PH.5 Refusal of Accreditation and Right of Review

An applicant who has been notified of the intention to refuse accreditation may, within 28 days of being notified, provide further information to the Minister which may be taken into consideration prior to a final decision being made.

Applicants refused accreditation or any person affected by the decision have the right to appeal to the Administrative Appeals Tribunal.

PH.6 National Pathology Accreditation Advisory Council (NPAAC)

NPAAC was established in 1979. Its functions are to develop policy for accreditation of pathology laboratories, introduce and maintain uniform standards of practice in pathology services throughout Australia and initiate and coordinate educational programs in relation to pathology practice. The agencies used to inspect laboratories on the Commonwealth's behalf are required to conduct inspections using the standards set down by NPAAC. For further information the NPAAC Secretariat can be contacted on (02) 6289 4017 or email npaac@health.gov.au.

PH.7 Change of Address/Location

Laboratories are accredited for the particular premises given on the application form. Where a laboratory is relocated to other premises, any previously issued approvals for that Accredited Pathology Laboratory lapse. Medicare benefits are not payable for any pathology services performed at the new location until a new application has been approved by the Minister for Health and Ageing. Paragraph [PH.2](#) sets out the method for applying for accreditation.

PH.8 Change of Ownership of a Laboratory

Part of the assessment of an application for an Accredited Pathology Laboratory relates to the Approved Pathology Authority status. Where the ownership, or some other material change occurs affecting the laboratory, the Minister for Health and Ageing must be provided with those changed details. Medicare benefits will not be payable for any pathology services performed on any premises other than those premises for which approval has been given.

PH.9 Approved Collection Centres (ACC)

New arrangements for specimen collection centres commenced on 1 December 2001 and replaced the Licensed Collection Centre (LCC) Scheme.

Transition arrangements have been negotiated to phase in the new arrangements over four years to allow the pathology sector to adjust to a less regulated environment.

To enable the payment of Medicare benefits for pathology services performed on pathology specimens collected in a collection centre, the centre must first be approved. The exception to this rule is collection centres on the premises of recognised hospitals (recognised hospital in this context means the same as "recognized hospital" in Part 1 Section 3 of the Health Insurance Act 1973) as they do not need approval.

The number of collection centres an Approved Pathology Authority can operate under Medicare is primarily determined on the basis of its Medicare and Department of Veterans' Affairs pathology activity.

In order for a collection centre to be approved, a public or private Approved Pathology Authority must submit a completed application form to the Health Insurance Commission including details of the type of application (renewal, new or

cancellation of collection centre), the location of the premises, the owner and the staff to be employed at the centre, and any leasing arrangements. Staff working at the centre must be employed by the Approved Pathology Authority.

Application forms can be accessed by going to the Health Insurance Commission website www.hic.gov.au. Completed application forms and any enquiries should be forwarded to the Manager, Pathology Section, Health Insurance Commission, PO Box 1001, TUGGERANONG ACT 2901.

PI. APPROVED PATHOLOGY PRACTITIONERS

PI.1 Introduction

A pathology service will not attract Medicare benefits unless that service is provided by or on behalf of an Approved Pathology Practitioner. (Approved Pathology Practitioners must be registered medical practitioners.) Set out below is information which relates to Approved Pathology Practitioner requirements.

PI.2 Applying for Acceptance of the Approved Pathology Practitioner Undertaking

To apply for acceptance of an Approved Pathology Practitioner Undertaking, it is necessary to send:

- (i) a completed application for acceptance of an Approved Pathology Practitioner Undertaking; and
- (ii) a signed Approved Pathology Practitioner Undertaking to the Pathology Registration Co-ordinator, Health Insurance Commission, PO Box 9822 (in your capital city).

An application form, undertaking and associated literature can be obtained from the Pathology Registration Co-ordinator.

PI.2.1 *Payment of Acceptance Fee*

On receipt of advice that the Minister has accepted an undertaking, a cheque for \$500 should be despatched to the Pathology Registration Co-ordinator. Applicants are required to pay this fee within 14 days of the notice being given (ie. the day the notice is sent).

As there is no discretion under the *Health Insurance Act 1973* to accept late payments, failure to pay the fee within the required time means that:

- (i) acceptance of the undertaking will be revoked;
- (ii) a new application must be completed;
- (iii) acceptance of the new undertaking cannot be backdated; and
- (iv) there will therefore be a period during which Medicare benefits cannot be paid.

PI.2.2 *Reminder Process*

In administering the Approved Pathology Authority and Approved Pathology Practitioner arrangements, the Health Insurance Commission provides reminders to ensure that:

- (i) applicants whose undertaking are about to expire are aware of the consequences of late lodgement; and
- (ii) where the 14 day period for payment of fees is about to expire and the fees have not been paid, that applicants are aware of the consequences of failure to pay on time.

PI.3 Undertakings

PI.3.1 *Consideration of Undertakings*

The Minister is unable to accept an undertaking from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, amongst other things, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Practitioner.

When an undertaking has been given, the Minister may require the person giving the undertaking to provide additional information within a fixed period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PI.3.2 Refusal of Undertaking and Rights of Review

Where the Minister refuses to accept an undertaking, for any of the reasons shown above, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PI.3.3 Effective Period of Undertaking

The following applies:

- (i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;
- (ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving undertakings of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;
- (iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Health Insurance Commission until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and
- (iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Practitioner may terminate an undertaking at any time providing that the practitioner gives at least 30 days notice of his/her intention to do so.

PI.4 Obligations and Responsibilities of Approved Pathology Practitioners

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Practitioners and the Minister. The more complex of these not already dealt with are considered in PK, PL and PM dealing with Breaches of Undertakings, Excessive Pathology Services and Personal Supervision.

PJ. APPROVED PATHOLOGY AUTHORITIES

PJ.1 Introduction

A pathology service will not attract Medicare benefits unless the proprietor of the laboratory in which the pathology service is performed is an Approved Pathology Authority. Following is information which relates to Approved Pathology Authority requirements.

PJ.2 Applying for Acceptance of an Approved Pathology Authority Undertaking

To apply for acceptance of an Approved Pathology Authority Undertaking, it is necessary to send:

- (i) a completed application for acceptance of an Approved Pathology Authority Undertaking; and
- (ii) a signed Approved Pathology Authority Undertaking.

to the Pathology Registration Co-ordinator, Health Insurance Commission, PO Box 9822 (in your capital city). Application forms, undertakings and associated literature can be obtained from the Pathology Registration Co-ordinator.

The application and the undertaking should be completed by the proprietor of the laboratory/ies and where the proprietor is not a natural person (e.g. company or partnership), an authorised representative/s should complete the forms. This proprietor can be:

- (i) a natural person;
- (ii) partners (natural persons and/or companies) in a partnership;
- (iii) a body corporate (i.e. a company); or
- (iv) a government authority (e.g. a public hospital).

PJ.2.1 *Payment of Acceptance Fee*

On receipt of advice that the Minister has accepted an undertaking, a cheque for \$1,500 should be dispatched within 14 days or the undertaking will be cancelled and the whole process begun again with a consequent gap in the payment of benefits.

PJ.3 Undertakings

PJ.3.1 *Consideration of Undertakings*

The Minister is unable to accept undertakings from a person in respect of whom there is a determination in force that the person has breached the undertaking, or from a person who, if the undertaking were accepted, would be likely to carry on the business of a prescribed person or would enable a person to avoid the financial consequences of the disqualification (or likely disqualification) of that prescribed person. A 'prescribed person' includes, inter alia, fully or partially disqualified persons (or persons likely to be so disqualified).

Similarly an undertaking cannot be accepted unless the Minister is satisfied that the person giving such undertaking is a fit and proper person to be an Approved Pathology Authority.

When an undertaking has been given the Minister may require the person giving the undertaking to provide additional information within a specified period of time and if the person does not comply the Minister may refuse to accept the undertaking.

PJ.3.2 *Refusal of Undertaking and Rights of Review*

Where the Minister refuses to accept an undertaking, the Minister must notify the person of the decision. The notification must include advice of a right of internal review of the decision and a right of further appeal to the Administrative Appeals Tribunal if the internal review upholds the original decision to refuse the undertaking.

PJ.3.3 *Effective Period of Undertaking*

The following applies:

- (i) Date of Effect - the earliest day from which the Minister or delegate can accept an undertaking is the day of the decision in respect of the undertaking. The day the undertaking is signed is to be the day it is actually signed and must not be backdated;
- (ii) Period of Effect - in determining the period of effect of the undertaking the Minister shall, unless the Minister considers that special circumstances exist, determine that the period of effect shall be twelve months from the day on which the undertaking comes into force. There is a requirement for the Minister to notify persons giving an undertaking of the period of time for which the undertaking is to have effect, and the notice is to advise persons whose interests are affected by the decision of their rights of appeal to the Administrative Appeals Tribunal against the Minister's decision;
- (iii) Renewals - when an undertaking is given and accepted by the Minister while a former undertaking is current, the new undertaking does not take effect until the former undertaking ceases to be in force. When

an undertaking is given while a former undertaking is current and the date on which the former undertaking is to expire passes without the Minister giving notice to accept or reject the new undertaking, the former undertaking remains in force until the Minister gives such notification. This provision does not apply when the renewal application is not received by the Health Insurance Commission until after the expiry of the existing undertaking. Under these circumstances there will be a period during which Medicare benefits cannot be paid unless the new application can be backdated to the expiry of the previous undertaking. This is a limited discretion for periods up to one month and special conditions apply; and

- (iv) Cessation of Undertaking - the undertaking ceases to be in force if it is terminated, if the Minister revokes acceptance of the undertaking, or if the period of effect for the undertaking expires - whichever event first occurs.

An Approved Pathology Authority may terminate an undertaking at any time providing that at least 30 days notice of the intention to terminate the undertaking is given.

PJ.4 Obligations and Responsibilities of Approved Pathology Authorities

The requirements of the legislation and the undertaking impose a number of obligations and responsibilities on Approved Pathology Authorities and the Minister. The more complex of these which have not already been covered are considered in paragraphs PK and PL dealing with Breaches of Undertakings and Excessive Pathology Services.

PK. BREACHES OF UNDERTAKINGS

PK.1 Notice Required

Where the Minister has reasonable grounds for believing that an Approved Pathology Practitioner or an Approved Pathology Authority has breached the undertaking, the Minister is required to give notice in writing to the person explaining the grounds for that belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PK.2 Decisions by Minister

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively the Minister may refer the matter to a Medicare Participation Review Committee, notifying the grounds for believing that the undertaking has been breached. If after 28 days no submission has been received from the person, the Minister must refer that matter to the Committee.

PK.3 Appeals

The Minister is empowered to suspend an undertaking where notice has been given to a Medicare Participation Review Committee of its possible breach, pending the outcome of the Committee's proceedings. The Minister must give notice in writing to the person who provided the undertaking of the determination to suspend it, and the notice shall inform the person of a right of appeal against the determination to the Administrative Appeals Tribunal. The Minister may also publish a notice of a determination in the Commonwealth Gazette. Rights of appeal to the Administrative Appeals Tribunal also exist in respect of any determination made by a Medicare Participation Review Committee.

PL. INITIATION OF EXCESSIVE PATHOLOGY SERVICES

PL.1 Notice Required

Where the Minister has reasonable grounds for believing that a person, of a specified class of persons, has initiated, or caused or permitted the initiation of excessive pathology services the Minister is required to give notice in writing to the person explaining the grounds for the belief and inviting the person to put a submission to the Minister to show cause why no further action should be taken in the matter.

PL.2 Classes of Persons

The classes of persons are:

- (i) the practitioner who initiated the services;
- (ii) the employer of the practitioner who caused or permitted the practitioner to initiate the services; or

- (iii) an officer of the body corporate employing the practitioner who caused or permitted the practitioner to initiate the services.

PL.3 Decisions by Minister for Health and Ageing

Where a person provides a submission, the Minister may decide to take no further action against the person. Alternatively, the Minister may refer the matter to a Professional Services Review (PSR) Committee, notifying the grounds for believing that excessive pathology services have been initiated. If after 28 days no submission has been received from the person, the Minister must refer the matter to the Committee. The Minister must give to the person notice in writing of the decision.

PL.4 Appeals

Unlike the procedures relating to breaches of undertaking there is no power given to the Minister to determine a penalty. The Minister's role is either deciding to take no further action or referring the matter to a PSR Committee. Accordingly, there are no rights of appeal to the Administrative Appeals Tribunal applicable to the above procedures. However, rights of appeal to the Administrative Appeals Tribunal exist in respect of any determination made by a Medicare Participation Review Committee.

PM. PERSONAL SUPERVISION

PM.1 Introduction

The *Health Insurance Act 1973* provides that the form of undertaking to be given by an Approved Pathology Practitioner may make provision for pathology services carried out under the personal supervision of the Approved Pathology Practitioner.

PM.2 Extract from Undertaking

The following is an extract from the Approved Pathology Practitioner (APP) undertaking:

PART 1 - PERSONAL SUPERVISION

- 1) Subject to clause 2, I undertake that where a service is rendered on my behalf, I will accept personal responsibility for the rendering of that service under the following conditions of personal supervision -
 - a) Where a service is rendered on my behalf, I must usually be physically available in the laboratory during the rendering of that service.
 - b) I may be absent from the laboratory for brief periods where the absence is due to illness or other personal exigency, or involves activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory. If such an absence occurs, and it does not exceed 7 consecutive days, then I will be regarded as continuing to personally supervise the rendering of services.
 - c) Where I am absent from the laboratory for more than 7 consecutive days, I must arrange for another approved pathology practitioner to personally supervise the rendering of services in the laboratory which would otherwise be rendered by me or on my behalf. Where such an arrangement is made, then I will be regarded as continuing to personally supervise the rendering of services.
 - d) For the purposes of the *Health Insurance Act 1973*, services will not be regarded as being rendered by me or on my behalf during any absence, for any reason, which occurs after I have already been absent for a total of 14 working days in any month that services are rendered.
 - e) If a service is being rendered on my behalf outside the normal hours of operation of the laboratory, I must be able to be contacted at the time that the service is being rendered by the person who is rendering the service. If required, I must be able to personally attend at the laboratory during the rendering of the service.
 - f) If a service is being rendered on my behalf by a person who is not -
 - i) a medical practitioner;
 - ii) a scientist; or
 - iii) a person having special qualifications or skills relevant to the service being rendered;

and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service.

- g) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:
 - i) all persons who render services are adequately trained;
 - ii) all services which are to be rendered in the laboratory are allocated to persons with appropriate qualifications and experience to render the services;
 - iii) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices;
 - iv) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and
 - v) results of services and tests rendered are accurately recorded and reported.

PM.3 Notes on the Above

Part 1 of the APP Undertaking outlines the requirements for the personal supervision by an Approved Pathology Practitioner where a pathology service is rendered by another person on behalf of the APP. It should be noted that "on behalf of" does not relieve an Approved Pathology Practitioner of professional responsibility for the service or from being personally involved in the supervision of services in the laboratory.

PN. CHANGES TO THE PATHOLOGY SERVICES TABLE

PN.1 Health Insurance Regulations

The *Health Insurance Act 1973* allows the Minister for Health and Ageing to determine an appropriate Pathology Services Table which is then prescribed by Regulation.

The Minister has established the Pathology Services Table Committee (PSTC) to assist in determining changes to the Table (except new medical services and technologies - see below). Any person or organisation seeking to make a submission to this Committee can contact the PSTC Secretariat on (02) 6289 4081 or e-mail pstc@health.gov.au and/or write to: Secretary, PSTC, MDP 107, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601.

Pathology submissions relating to new medical services and technologies should be forwarded to the Medical Services Advisory Committee (MSAC). MSAC has been established to advise the Minister on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported.

Any person or organisation seeking to make a submission to MSAC can contact the MSAC Secretariat on (02) 6289 6811 or email msac.secretariat@health.gov.au and/or write to: Director, Strategic Policy Section, Department of Health and Ageing, GPO Box 9848, CANBERRA ACT 2601. The application form and guidelines for applying can also be obtained from MSAC's website - www.health.gov.au/haf/msac.

EXPLANATORY NOTES

PO. DEFINITIONS

PO.1 Excessive Pathology Service

This means a pathology service for which a Medicare benefit has become or may become payable and which is not reasonably necessary for the adequate medical or dental care of the patient concerned.

PO.2 Group of Practitioners

This means:

- (i) a practitioner conducting a medical practice or a dental practice together with another practitioner, or other practitioners, participating (whether as employees or otherwise) in the provision of professional services as part of that practice; or

- (ii) two or more practitioners conducting a medical practice or a dental practice as partners; or
- (iii) those partners together with any other practitioner who participates (whether as an employee or otherwise) in the provision of professional services as part of that practice.

PO.3 Initiate

In relation to a pathology service this means to request the provision of pathology services for a patient.

PO.4 Patient Episode

A patient episode comprises a pathology service or services specified in one or more items which are provided for a single patient, the need for which was determined under subsection 16A(1) of the Act on the same day, whether they were provided by one or more approved pathology practitioners on one day or over several days and whether they are requested by one or more treating practitioners. Even if a treating practitioner writes separate request forms to cover the collection of specimens at different times, where the decision to collect the multiple specimens was made at the same time, the multiple tests are deemed to belong to the same patient episode. In addition, if more than one request is made, on the same or different days, for tests on the same specimen within 14 days, they are part of the same patient episode.

Rule 4 of the Pathology Services Table provides an exemption to the above and enables services requested on one day which are performed under strictly limited circumstances for seriously or chronically ill patients with certain specified conditions to each be classified as a patient episode. See [PD.2](#) for further information on exemptions.

Rule 15.(8) also provides that only a single patient episode initiation fee will be payable for all the specimens collected on one day from one patient in or by one Approved Pathology Authority.

PO.5 Episode Cone

The episode cone is an arrangement, described in [rule 19](#), which effectively places an upper limit on the number of items for which Medicare benefits are payable in a patient episode. This cone only applies to services requested by general practitioners for their non-hospitalised patients. Pathology services requested for hospital in-patients, or ordered by specialists, are not subject to these coning arrangements.

When more than 3 items are requested by a general practitioner in a patient episode, the benefits payable will be equivalent to the sum of the benefits for the three items with the highest Schedule fees. [rule 19](#) provides that for the two items with the highest Schedule fees, Medicare benefits will be payable for each item. The remaining items are regarded as one service for which the benefit payable will be equivalent to that for the item with the third highest Schedule fee. Where items have the same Schedule fee, their item numbers are used as an artificial means to rank them.

The episode cone will apply even when the pathology services in a patient episode are performed by 2 or more Approved Pathology Authorities, with the exception of the services listed below.

The following items are not included in the count of the items performed when applying the episode cone:

- (i) all the items in Groups [P10](#) and [P11](#);
- (ii) Pap smear testing (items [73053](#) and [73055](#)); and
- (iii) designated pathology services (items [66620](#), [66713](#), [66737](#) and [69402](#)).

PO.6 Personal Supervision

This means that an Approved Pathology Practitioner will, to the fullest extent possible, be responsible for exercising an acceptable level of control over the rendering of pathology services. See [PM.1](#) to [PM.3](#) for a full description of the responsibilities involved in personal supervision.

PO.7 Prescribed Pathology Service

These are simple basic pathology services which are included in Group [P9](#) and may be performed by a medical practitioner in the practitioner's surgery without the need to obtain Approved Pathology Authority, Approved Pathology Practitioner or Accredited Pathology Laboratory status.

PO.8 Proprietor of a Laboratory

This means in relation to a pathology laboratory the person, authority or body of persons having effective control of:

- (i) the laboratory premises, whether or not the holder of an estate or interest in the premises;
- (ii) the use of equipment used in the laboratory; and
- (iii) the employment of staff in the laboratory.

PO.9 Specialist Pathologist

This means a medical practitioner recognised for the purposes of the *Health Insurance Act 1973* as a specialist in pathology (see [5.1](#) of the "General Explanatory Notes" in Section 1 of this book). The principal specialty of pathology includes a number of sectional specialties. Accordingly, a medical practitioner who is recognised as a specialist in a sectional specialty of pathology is recognised as a specialist pathologist for this purpose.

PO.10 Designated Pathology Service

This means a pathology service specified in items [66620](#), [66713](#), [66737](#) or [69402](#). Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some but not all the estimations in a coned item and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the rest, the service provided by the second practitioner is deemed to be the "designated pathology service". Thus the first practitioner claims under the appropriate item for the services which he/she provides while the second practitioner claims one of items [66620](#), [66713](#), [66737](#) or [69402](#). Where one Approved Pathology Practitioner in an Approved Pathology Authority has performed some, but not all estimations and has requested another Approved Pathology Practitioner in another Approved Pathology Authority to do the remainder, the first Approved Pathology Practitioner can raise a "patient episode initiation fee". The second Approved Pathology Practitioner who receives the specimen can raise a "specimen referred fee".

PP. INTERPRETATION OF THE SCHEDULE

PP.1 Faecal Occult Blood (Item [66764](#) - [66770](#))

The fee for item [66764-66770](#) is only payable where both test methods described in the item have been performed.

PP.2 Tissue Pathology and Cytology (Items [72813](#) - [73060](#))

When services described in Group [P5](#) need to be performed upon material which is submitted for cytology items listed in Group [P6](#) only the fee for the [P6](#) item can be claimed.

PP.3 Cervical and Vaginal Cytology (Items [73053](#) - [73057](#))

Item [73053](#) applies to the cytological examination of cervical smears collected from women with no symptoms, signs or recent history suggestive of cervical neoplasia as part of routine, biennial examination for the detection of pre-cancerous or cancerous changes. This item also applies to smears repeated due to an unsatisfactory routine smear, or if there is inadequate information provided to use item [73055](#).

Cytological examinations carried out under item [73053](#) should be in accordance with the agreed National Policy on Screening for the Prevention of Cervical Cancer. This policy provides for:

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

This policy has been endorsed by the Royal Australian College of General Practitioners, the Royal Australian College of Obstetricians and Gynaecologists, The Royal College of Pathologists of Australasia, the Australian Cancer Society and the National Health and Medical Research Council.

The *Health Insurance Act 1973* excludes payment of Medicare benefits for health screening services except where Ministerial directions have been issued to enable benefits to be paid, such as the Papanicolaou test. As there is now an established policy

which has the support of the relevant professional bodies, routine screening in accordance with the policy will be regarded as good medical practice.

The screening policy will not be used as a basis for determining eligibility for benefits. However, the policy will be used as a guide for reviewing practitioner profiles.

Item [73055](#) applies to cervical cytological examinations where the smear has been collected for the purpose of management, follow up or investigation of a previous abnormal cytology report, or collected from women with symptoms, signs or recent history suggestive of abnormal cervical cytology.

Items [73057](#) applies to all vaginal cytological examinations, whether for a routine examination or for the follow up or management of a previously detected abnormal smear.

For cervical smears, treating practitioners are asked to clearly identify on the request form to the pathologist, by item number, if the smear has been taken as a routine examination or for the management of a previously detected abnormality.

PP.4 Eosinophil Cationic Protein (Item [71095](#))

Item [71095](#) applies to children aged less than 12 years who cannot be reliably monitored by spirometry or flowmeter readings.

PP.5 Lithium

A test for the quantitation of lithium is claimable under item [66611](#) - 'quantitation of a drug being used therapeutically'.

PP.6 Antibiotics/Antimicrobial Chemotherapeutic Agents

A test for the quantitation of antibiotics/antimicrobial chemotherapeutic agents is claimable under item [66611](#) - 'quantitation of a drug being used therapeutically'.

PP.7 Items referring to the 'detection of'

Items that contain the term 'detection of' should be taken to mean 'testing for the presence of'.

PP.8 Blood Grouping (Item [65096](#))

Where a request includes 'Group and Hold' or 'Group and Save', the appropriate item is [65096](#).

PP.9 Iron Studies (Item [66596](#))

Where a request includes 'Iron Studies', 'IS', 'Fe', '% saturation' or 'Iron', the relevant item is [66596](#).

PP.10 Glycosylated haemoglobin (Item [66551](#))

The requirement of "established diabetes" in this item may be satisfied by: a)
a statement of the diagnosis by the ordering practitioner on the current request form or on a previous request form held the database of the Approved Pathology Authority; or
b) two or more blood glucose levels that are in the diabetic range and is contained in the database of the Approved Pat Authority; or
c) an oral glucose tolerance test result that is in the diabetic range and is contained in the database of the Approved Pathology Authority.

PP.11 Hepatitis (Items [69475](#), [69478](#), [69481](#), [69484](#), [69487](#), [69490](#) and [69493](#))

- (a) Benefits for item [69478](#) are payable only if the request form from the ordering practitioner contains a request for two tests for immune status or carriage, either in general or specific terms. Alternatively, the clinical notes must indicate that the test is for pre-operative assessment or post-exposure to blood or bodily fluids or prior to blood or tissue donation.

- (b) Benefits for item [69481](#) are payable only if the request from the ordering practitioner indicates in writing that the patient is suspected of suffering from acute or chronic hepatitis; either by the use of the provisional diagnosis of hepatitis or by relevant clinical or laboratory information eg "hepatomegaly", "jaundice" or "abnormal liver function tests".

PQ. ABBREVIATIONS, GROUPS OF TESTS

PQ.1 Abbreviations

As stated at [PC.2](#) of the Outline, details that must be recorded on accounts, receipts or assignment forms of an Approved Pathology Practitioner/Authority include a description of the pathology service that is of sufficient detail to identify the specific service rendered. The lists of abbreviations for group tests are contained in PQ.4. The lists of abbreviations for individual tests are contained in the Index to this Section. The abbreviations are provided to allow users to identify and refer to particular pathology services, or particular groups of pathology services, more accurately and conveniently.

The above requirements may be used for billing purposes but treating practitioners requesting pathology services are encouraged to use the approved abbreviations. In this regard treating practitioners should note that:

- pathology services cannot be self determined by a rendering pathologist responding to a request. This places the onus for medical necessity on the treating practitioner who, in normal circumstances would, if he or she was unclear in deciding the appropriate test for a clinical situation, consult a pathologist for assistance; and
- Approved Pathology Practitioners/Authorities undertake not to issue accounts etc unless the pathology service was rendered in response to an unambiguous request.

PQ.2 Tests not Listed

Tests which are not listed in the Pathology Services Table do not attract Medicare benefits. As explained at [PN.1](#) of the Outline, changes to the Pathology Services Table can only be made by the Minister for Health and Ageing.

PQ.3 Audit of Claims

The Health Insurance Commission is undertaking routine audits of claims for pathology benefits against requested services to ensure compliance with the provisions of the *Health Insurance Act 1973*.

PQ.4 Groups of Tests

For the purposes of recording a description of the pathology service on accounts etc, an Approved Pathology Practitioner /Authority may use group abbreviations or group descriptions for the following specified groups of tests. These groups consist of two or more tests within the same item.

Treating practitioners are encouraged to use these group abbreviations or group descriptions where appropriate.

For ease of identification of group tests, it is recommended that practitioners use the following abbreviations. Tests requested individually may attract Medicare benefits.

Group	Estimations Included in Group	Group Abbreviation	Item Numbers
Cardiac enzymes or cardiac markers	Creatine kinase isoenzymes, myoglobin, troponin	CE / CM	66518 , 66519
Coagulation studies	Prothrombin time, activated partial thromboplastin time and two or more of the following tests- fibrinogen, thrombin clotting time, fibrinogen degradation products, fibrin monomer, D-dimer factor XIII screening tests	COAG	65129
Electrolytes	Sodium (NA) potassium (K) chloride (CL) and bicarbonate (HCO3)	E	66509

Group	Estimations Included in Group	Group Abbreviation	Item Numbers
Full Blood Examination	Erythrocyte count Haematocrit Haemoglobin Platelet count Red cell count Leucocyte count Manual or instrument generated differential Morphological assessment of blood film where appropriate	FBE, FBC, CBC	65070
Lipid studies	Cholesterol (CHOL) and triglycerides (TRIG)	FATS	66500
Liver function tests	Alkaline phosphatase (ALP), alanine aminotransferase (ALT), aspartate aminotransferase (AST), albumin (ALB), bilirubin (BIL), gamma glutamyl transpeptidase (GGT), lactate dehydrogenase (LDH), and protein (PROT).	LFT	66515
Syphilis serology	Rapid plasma reagin test (RPR), or venereal disease research laboratory test (VDRL), and treponema pallidum haemagglutinin test (TPHA), or fluorescent treponemal antibody-absorption test (FTA)	STS	69387
Urea, electrolytes, creatinine	Urea, electrolytes, creatinine	U&E	66515

PR. COMPLEXITY LEVELS FOR HISTOPATHOLOGY ITEMS

PR.1 Complexity Levels

Only one of these histopathology examination items ([72813](#), [72816](#), [72817](#), [72823](#), [72824](#), [72825](#), [72830](#) and [72836](#)) can be claimed in a patient episode.

The remaining items ([72846](#), [72847](#), [72851](#), [72852](#), [72855](#) and [72856](#)) are add-on items, covering immunohistochemistry, electron microscopy and frozen sections, which can be claimed in addition to the main item when ordered by the requesting practitioner.

Immunohistochemistry items [72846](#) and [72847](#) and immunocytochemistry items [73059](#) and [73060](#) are 'Pathologist-determinable services' for tissue examination items [72813](#) to [72836](#) and cytology items [73045](#) to [73051](#) respectively.

The list of complexity levels by type of specimen are contained at the back of this Section.

PX. PATHOLOGY SERVICES TABLE

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

1. (1) In this table

patient episode means:

- (a) a pathology service or pathology services (other than a pathology service to which paragraph 1 (1) (b) refers) provided for a single patient whose need for the service or services was determined under section 16A of the Act:
 - (i) on the same day; or
 - (ii) if more than 1 test is performed on the 1 specimen within 14 days - on the same or different days;whether the services:
 - (iii) are requested by 1 or more practitioners; or
 - (iv) are described in a single item or in more than 1 item; or
 - (v) are rendered by 1 approved pathology practitioner or more than 1 approved pathology practitioner; or
 - (vi) are rendered on the same or different days; or
- (b) a pathology service to which rule 4 refers that is provided in the circumstances set out in that rule that relates to the service.

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

serial examinations means a series of examinations requested on 1 occasion whether or not:

- (a) the materials are received on different days by the approved pathology practitioner; or
- (b) the examinations or cultures were requested on 1 or more request forms by the treating practitioner.

the Act means the *Health Insurance Act 1973*.

- 1. (2) In these rules, a reference to a request to an approved pathology practitioner includes a reference to a request for a pathologist-determinable service to which subsection 16A (6) of the Act applies.
- 1. (3) A reference in this table by number to an item that is not included in this table is a reference to the item that has that number in the general medical services table or the diagnostic imaging services table, as the case requires.
- 1. (4) A reference to a Group in the table includes every item in the Group.

Precedence of items

- 2. (1) If a service is described:
 - (a) in an item in general terms; and
 - (b) in another item in specific terms;only the item that describes the service in specific terms applies to the service.
- 2. (2) Subject to subrule (3), if:
 - (a) subrule (1) does not apply; and
 - (b) a service is described in 2 or more items;only the item that provides the lower or lowest fee for the service applies to the service.
- 2. (3) If an item is expressed to include a pathology service that is described in another item, the other item does not apply to the service in addition to the first-mentioned item, whether or not the services described in the 2 items are requested separately.

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

- 3. (1) In subrule 3(2), **service** includes assay, estimation and test.
- 3. (2) Two or more pathology services (other than services to which, under rule 4, this rule does not apply) rendered for a patient following 2 or more requests are taken to have been rendered following a single request if:
 - (a) the services are listed in the same item; and
 - (b) the patient's need for the services was determined under subsection 16A (1) of the Act on the same day even if the services are rendered by an approved pathology practitioner on more than one day.

Services to which rule 3 does not apply

4. (1) Rule 3 does not apply to a pathology service described in item [66500](#), [66503](#), [66506](#), [66509](#), [66512](#) and [66515](#) or [66584](#), if:
- (a) the service is rendered in relation to a single specimen taken on each of not more than 4 occasions in a period of 24 hours; and
 - (b) the service is rendered to a patient in a hospital unit where:
 - (i) the presence of 1 nurse is required for each group of not more than 4 patients; and
 - (ii) the condition of the patients is continuously observed in relevant respects; and
 - (c) in order to render the service, an approved pathology practitioner who is a recognised pathologist has to arrange for a member of the laboratory staff of the approved pathology authority concerned to undertake duties in respect of the service that are in addition to the usual duties of the staff member; and
 - (d) the account for the service is endorsed 'Rule 3 Exemption'.
4. (2) Rule 3 does not apply to any of the following pathology services:
- (a) estimation of prothrombin time (INR) in respect of a patient undergoing anticoagulant therapy;
 - (b) quantitative estimation of lithium in respect of a patient undergoing lithium therapy;
 - (c) a service described in item [65070](#) in relation to a patient undergoing chemotherapy for neoplastic disease or immunosuppressant therapy;
 - (d) a service described in item [65070](#) in relation to clozaril, ticlopidine hydrochloride, methotrexate, gold, sulphasalazine or penicillamine therapy of a patient;
 - (e) a service described in item [66500](#) - [66515](#) in relation to methotrexate or leflunomide therapy of a patient;
 - (f) quantitative estimation of urea, creatinine and electrolytes in relation to:
 - (i) cis-platinum or cyclosporin therapy of a patient; or
 - (ii) chronic renal failure of a patient being treated in a dialysis program conducted by a recognised hospital;
 - (g) quantitative estimation of albumin and calcium in relation to therapy of a patient with vitamin D, its metabolites or analogues;
- if:
- (h) under a request for a service, other than a request for a service described in paragraph (a), no more than 6 tests are requested; and
 - (i) the tests are performed within 6 months of the request; and
 - (j) the account for the service is endorsed "Rule 3 Exemption".

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

5. (1) For an item in Group [P1](#) (Haematology):
- (a) if pathology services of a kind referred to in item [65090](#) or [65093](#) are rendered for a patient during a period when the patient is in hospital, the item applies only to the first pathology service of that kind rendered for the patient during the period; and
 - (b) if:
 - (i) tests (except tests mentioned in item [65099](#), [65102](#), [65105](#) and [65108](#)) are carried out in relation to a patient episode; and
 - (ii) specimen material from the patient episode is stored; and
 - (iii) in response to a request made within 14 days of the patient episode, further tests (except tests mentioned in item [65099](#), [65102](#), [65105](#) and [65108](#)) are carried out on the stored material; the later tests and the earlier tests are taken to be part of one patient episode.
5. (2) Benefits for items [65102](#) and [65108](#) are payable only if a minimum of 6 units are issued for the patient's care in any 1 day.
- 5.(3) For items [65099](#) and [65102](#):

compatibility tests by crossmatch means that, in addition to all the tests described in paragraphs (a) and (b) of the item, donor red cells from each unit must have been tested directly against the serum of the patient by 1 or more accepted crossmatching techniques.

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

6. (1) In this rule:

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

- (a) tests of the kind described in item [66611](#); or
- (b) tests of the kind described in item [66695](#); or
- (c) tests of the kind described in item [66722](#); or
- (d) tests of the kind described in item [69384](#).

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

- (a) an approved pathology practitioner (**practitioner A**) in an approved pathology authority:
 - (i) has been requested to render the designated pathology service; and
 - (ii) is unable, because of the lack of facilities in, or expertise or experience of the staff of, the laboratory of the authority, to render 1 or more (but not all) of the tests included in the service; and
 - (iii) requests an approved pathology practitioner (**practitioner B**) in another approved pathology authority to render the test or tests that practitioner A is unable to render; and
 - (iv) renders each test included in the service, other than the test or tests in respect of which the request mentioned in subparagraph (iii) is made: and
- (b) the tests mentioned in subparagraph (a) (iv) that practitioner A renders are not tests constituting a service described in item [66617](#), [66710](#), [66734](#) or [69399](#).

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

item [66611](#), [66614](#), [66695](#), [66698](#), [66701](#), [66704](#), [66707](#), [66722](#), [66725](#), [66728](#), [66731](#), [69384](#), [69387](#), [69390](#), [69393](#) or [69396](#) (as the case requires) applies in respect of the test or tests rendered by practitioner A; and

- (b) where practitioner B renders a service under a request referred to in subparagraph (2) (a) (iii) - subject to subrule (4), the amount specified in item [66620](#), [66713](#), [66737](#) or [69402](#) (as the case requires) is payable for each test that the service comprises.

6. (4) For paragraph (3) (b), the maximum number of tests to which item [66620](#), [66713](#), [66737](#) or [69402](#) applies is:

- (a) for item [66620](#):
3 - X; or
- (b) for item [66713](#), [66737](#) or [69402](#):
6 - X;

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

6. (5) Items in Group [P10](#) (Patient episode initiation) do not apply to the second-mentioned approved pathology practitioner in subrule (2).

Items not to be split

7. Except as stated in [rule 6](#), the amount specified in an item is payable only to one approved pathology practitioner in respect of a single patient episode.

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

8. Creatinine ratios - Group [P2](#) (chemical):

A pathology service mentioned in an item (except item [66500](#)) in Group [P2](#) (chemical) that:

- (a) involves the measurement of a substance in urine; and
 - (b) requires calculation of a substance/creatinine ratio;
- is taken to include the measurement of creatinine necessary for the calculation.

Thyroid function testing

9. (1) For item [66719](#):

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

9. (2) Except where paragraph (a) of item [66719](#) is satisfied, the amount specified in the item is not payable in respect of a pathology service described in the item unless the pathologist who renders the service has a written statement from the medical practitioner who requested the service that satisfies subrule (3).

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

- (a) that the tests are required for a particular purpose, being a purpose specified in paragraph (b) of item [66719](#); or
- (b) that the medical practitioner who requested the tests suspects the patient has pituitary dysfunction; or
- (c) that the patient is on drugs that interfere with thyroid hormone metabolism or function.

Meaning of "serial examinations or cultures"

10. For an item in Group [P3](#) (Microbiology):

- (a) **serial examinations or cultures** means a series of examinations or cultures requested on 1 occasion whether or not:
 - (i) the materials are received on different days by the approved pathology practitioner; or
 - (ii) the examinations or cultures were requested on 1 or more request forms by the treating practitioner; and
- (b) if:
 - (i) tests are carried out in relation to a patient episode; and
 - (ii) specimen material from the patient episode is stored; and
 - (iii) in response to a request made within 14 days of the patient episode, further tests are carried out on the stored material;

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

Investigation for hepatitis and syphilis serology

11. A medicare benefit is not payable in respect of more than one of items [69475](#), [69478](#), [69481](#), [69487](#), [69490](#) and [69493](#) in a patient episode.

Tests in Group [P4](#) (Immunology) relating to antibodies

12. For items in Group [P4](#) (Immunology), in items [71119](#), [71121](#), [71123](#) and [71125](#), if:

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

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

Tests on biopsy material - Group [P5](#) (Tissue pathology) and Group [P6](#) (Cytology)

13. (1) For items in Group [P5](#) (Tissue pathology):

- (a) **biopsy material** means all tissue (other than a bone marrow biopsy) received by the Approved Pathology Practitioner:
 - (i) from a medical procedure or group of medical procedures performed on a patient at the same time; or
 - (ii) after being expelled spontaneously from a patient.
- (b) **cytology** means microscopic examination of 1 or more stained preparations of cells separated naturally or artificially from their normal environment by methods recognised as adequate to demonstrate their structure to a degree sufficient to enable an opinion to be formed about whether they are likely to be normal, abnormal but benign, or abnormal and malignant but, in accordance with customary laboratory practice, does not include examination of a blood film and a bone marrow aspirate; and
- (c) **separately identified specimen** means an individual specimen collected, identified so that it is clearly distinguished from any other specimen, and sent for testing by or on behalf of the treating practitioner responsible for the procedure in which the specimen was taken.

13. (2) For Groups [P5](#) and [P6](#) of the pathology services table, services in Group [P6](#) include any services described in Group [P5](#) on the material submitted for a test in Group [P6](#).

13. (3) For subrule (2), any sample submitted for cytology from which a cell block is prepared does not qualify for a Group [P5](#) item.

- 13.(4) If more than 1 of the services mentioned in items [72813](#), [72816](#), [72817](#), [72823](#), [72824](#), [72825](#), [72830](#) and [72836](#) are performed in a single patient episode, a medicare benefit is payable only for the item performed that has the highest schedule fee.
- 13.(5) If more than 1 histopathological examinations are performed on separate specimens, of different complexity levels, from a single patient episode, a medicare benefit is payable only for the examination that has the highest schedule fee.
- 13.(6) In items [72813](#), [72816](#), [72817](#), [72823](#), [72824](#), [72825](#), [72830](#) and [72836](#) a reference to a *complexity level* is a reference to the level given to a specimen type mentioned in Part 4 of this Table.

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

14. (1) For this rule and items in Groups [P10](#) (Patient episode initiation) and [P11](#) (Specimen referred):

institution means a place at which residential accommodation or day care is, or both residential accommodation and day care are, made available to:

- (a) disadvantaged children; or
- (b) juvenile offenders; or
- (c) aged persons; or
- (d) chronically ill psychiatric patients; or
- (e) homeless persons; or
- (f) unemployed persons; or
- (g) persons suffering from alcoholism; or
- (h) persons addicted to drugs; or
- (i) physically or mentally handicapped persons; but does not include:
- (j) a hospital; or
- (k) a residential aged care home; or
- (l) accommodation for aged persons that is attached to a residential aged care home or situated within a residential aged care home.

approved collection centre has the same meaning as in Part IIA of the Act.

prescribed laboratory means a laboratory operated by:

- (a) the Commonwealth; or
- (b) a State or internal Territory; or
- (c) an authority of a State or internal Territory; or
- (d) an Australian tertiary education institution.

specimen collection centre has the same meaning as in Part IIA of the Act.

treating practitioner has the same meaning as in paragraph 16A(1)(a) of the Act.

14. (2) If a service described in an item in Group [P10](#) or [P11](#) is rendered by, or on behalf of, an approved pathology practitioner who is a recognised pathologist, the relevant one of those items does not apply to the service if:
- (a) the service is rendered upon a request made in the course of an out-patient service at a recognised hospital; or
 - (b) the service is rendered upon a request made for a patient who is a private patient in a recognised hospital when the request is made; or
 - (c) the pathology equipment of a recognised hospital, or a prescribed laboratory, is used rendering the service; or
 - (d) a member of the staff of a recognised hospital, or a prescribed laboratory, participates in the service in the course of the member's employment with the hospital or laboratory.
14. (3) An item in Group [P10](#) or [P11](#) does not apply to a pathology service to which subsection 16A (7) of the Act applies.
14. (4) An item in Group [P10](#) or [P11](#) does not apply to a pathology service unless at least 1 item in Groups [P1](#) to [P8](#) also applies to the service.
14. (5) Subject to subrule (7), if one item in Group [P10](#) applies to a patient episode, no other item in the Group applies to the patient episode.

14. (6) An item in Group [P11](#) applies only to the approved pathology practitioner or approved pathology authority to whom the specimen mentioned in the item was referred.
14. (7) If, in respect of the same patient episode:
- (a) services referred to in 1 or more items in Group [P5](#) and 1 or more of Groups [P1](#), [P2](#), [P3](#), [P4](#), [P6](#), [P7](#) and [P8](#) are rendered by an approved pathology practitioner in the laboratory of another approved pathology authority; or
 - (b) services referred to in 1 or more items in Group [P6](#) and 1 or more of Groups [P1](#), [P2](#), [P3](#), [P4](#), [P5](#), [P7](#) and [P8](#) are rendered by another approved pathology practitioner in another approved pathology authority; the fee specified in the applicable item in Group [P10](#) is payable to both approved pathology practitioners.
14. (8) If more than one specimen is collected from a person on the same day for the provision of pathology services:
- (a) in accordance with more than 1 request; and
 - (b) in or by a single approved pathology authority;
- only a single amount specified in the applicable item in Group [P10](#) is payable for the services.
14. (9) The amount specified in item [73921](#) is payable only once in respect of a single patient episode.

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

15. If item [73921](#) applies to a patient episode, none of the items in Group [P10](#) applies to any pathology service rendered by the approved pathology authority or approved pathology practitioner who claimed item [73921](#) in respect of the patient episode.

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

16. (1) An item in Group [P11](#) does not apply to a referral if:
- (a) a service in respect of the same patient episode has been carried out by the referring approved pathology authority; and
 - (b) the approved pathology authority to which the referral is made is related to the referring approved pathology authority.
16. (2) An approved pathology Authority is *related to* another approved pathology authority for subrule (1) if:
- (a) both approved pathology authorities are employed (including employed under contract) by the same person, whether or not the person is also an approved pathology authority; or
 - (b) either of the approved pathology authorities is employed (including employed under contract) by the other; or
 - (c) both approved pathology authorities are corporations and are related corporations within the meaning of the Corporations Law; or
 - (d) the approved pathology authorities are partners (whether or not either or both of the approved pathology authorities are individuals and whether or not other persons are in partnership with either or both of the approved pathology authorities).
16. (3) An item in Group [P11](#) does not apply to a referral if the following common tests are referred either singly or in combination (except if the following items are referred in combination with other items not similarly specified): [65060](#), [65070](#), [65120](#), [66500](#), [66503](#), [66506](#), [66509](#), [66512](#), [66515](#), [66536](#), [66596](#), [69300](#), [69303](#), [69333](#) or [73527](#).

Abbreviations

17. (1) The abbreviations in Part 3 of this table may be used to identify particular pathology services or groups of pathology services.
17. (2) The names of services or drugs not listed in Part 3 of this table must be written in full.

Certain pathology services to be treated as 1 service

18. (1) In this rule:

general practitioner means a medical practitioner who:

- (a) is not a consultant physician in any specialty; and
- (b) is not a specialist in any specialty;

set of pathology services means a group of pathology services:

- (a) that consists of services that are described in at least 4 different items; and
- (b) all of which are requested in a single patient episode; and
- (c) each of which relates to a patient who is not an admitted patient of a hospital; and
- (d) none of which is referred to:
 - (i) in item [66620](#), [66713](#), [66737](#), [69402](#), [73053](#) or [73055](#); or
 - (ii) in an item in Group [P10](#) (Patient episode initiation) or Group [P11](#) (Specimen referred).

- 18. (2)** If a general practitioner requests a set of pathology services, the pathology services in the set are to be treated as individual pathology services in accordance with this rule.
- 18. (3)** If the fee specified in 1 item that describes any of the services in the set of pathology services is higher than the fees specified in the other items that describe the services in the set:
- (a) the pathology service described in the first-mentioned item is to be treated as 1 pathology service; and
 - (b) either:
 - (i) the pathology service in the set that is described in the item that specifies the second-highest fee is to be treated as 1 pathology service; or
 - (ii) if 2 or more items that describe any of those services specify the second-highest fee - the pathology service described in the item that specifies the second-highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
 - (c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.
- 18. (4)** If the fees specified in 2 or more items that describe any of the services in the set of pathology services are the same, and higher than the fees specified in the other items that describe the services in the set:
- (a) the pathology service in the set that is described in the item that specifies the highest fee, and has the lowest item number, is to be treated as 1 pathology service; and
 - (b) the pathology service in the set that is described in the item that specifies the highest fee, and has the second-lowest item number, is to be treated as 1 pathology service; and
 - (c) the pathology services in the set, other than the services that are to be treated as 1 pathology service under paragraphs (a) and (b), are to be treated as 1 pathology service.
- 18. (5)** If pathology services are to be treated as one pathology service under paragraph (3) (c) or (4) (c), the fee for the one pathology service is the highest fee specified in any of the items that describe the pathology services that are to be treated as the 1 pathology service.

Hepatitis C viral RNA testing

- 19.** For item [69444](#):

Hepatitis C sero-positive, for a patient, means 2 different assays of Hepatitis C antibodies are positive.

serological status is uncertain, for a patient, means any result where 2 different assays of Hepatitis C antibodies are inconclusive.

Haemochromatosis testing

- 20.** For item [66794](#):

elevated serum ferritin for a patient, means a level of ferritin above the normal reference range in respect of the particular method of assay used to determine the level.

Serum B12 and red cell folate testing

- 21. (1)** For items [66599](#) and [66602](#), a medicare benefit is not payable for more than 3 episodes of services described in item [66599](#) or [66602](#), or any combination of those items, in a 12 month period.
- 21. (2)** A medicare benefit is not payable for a service described in item [66599](#) if the service was provided as part of the same patient episode as a service described in item [66602](#).

Nutritional and toxicity metals testing

22. (1) For this rule:
nutritional metals testing group means items [66669](#) and [66670](#). *metal toxicity testing group* means items [66672](#) and [66673](#).
22. (2) An item in the nutritional metals testing group or the metal toxicity testing group does not apply in relation to a service performed if medicare benefits are paid or payable for tests that are performed for the same patient in 3 patient episodes requested within 6 months before the request for that service, under any of:
- (a) that item; or
 - (b) the other item in the same group; or
 - (c) an item in the other group.

Antineutrophil Cytoplasmic Antibody

23. A request for ANCA shall be deemed to include requests for PR-3 ANCA and MPO ANCA where the immunofluorescence test for ANCA is abnormal, or has been abnormal, or these specific antibodies have been previously detected.

Gluten Hypersensitivity (including coeliac disease)

24. For item [71162](#) a request for autoantibodies testing for the diagnosis of gluten hypersensitivity includes a request for quantitation of serum total IgA antibodies (Item [71066](#)).

PATHOLOGY		PATHOLOGY	
65129	4 or more tests described in item 65120 Fee: \$35.00 Benefit: 75% = \$26.25 85% = \$29.75		
65132	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency, lupus anticoagulant, activated protein C resistance - if the request for the test specifically identifies in writing a history of venous thromboembolism - quantitation by 1 or more techniques - 1 test Fee: \$25.00 Benefit: 75% = \$18.75 85% = \$21.25		
65133	2 tests described in item 65132 Fee: \$48.00 Benefit: 75% = \$36.00 85% = \$40.80		
65134	3 tests described in item 65132 Fee: \$71.00 Benefit: 75% = \$53.25 85% = \$60.35		
65135	4 tests described in item 65132 Fee: \$94.00 Benefit: 75% = \$70.50 85% = \$79.90		
65136	5 tests described in item 65132 Fee: \$117.00 Benefit: 75% = \$87.75 85% = \$99.45		
65137	Test for the presence of lupus anticoagulant not being a service associated with any service to which items 65132 , 65133 , 65134 , 65135 and 65136 apply Fee: \$25.00 Benefit: 75% = \$18.75 85% = \$21.25		
65142	Confirmation or clarification of an abnormal or indeterminate result from a test described in item 65132 , by testing a specimen collected on a different day - 1 or more tests Fee: \$25.00 Benefit: 75% = \$18.75 85% = \$21.25		
65144	Platelet aggregation in response to ADP, collagen, 5HT, ristocetin or other substances; or heparin, low molecular weight heparins, heparinoid or other drugs - 1 or more tests Fee: \$55.80 Benefit: 75% = \$41.85 85% = \$47.45		
65147	Quantitation of anti-Xa activity when monitoring is required for a patient receiving a low molecular weight heparin or heparinoid - 1 test Fee: \$37.40 Benefit: 75% = \$28.05 85% = \$31.80		
65150	Quantitation of von Willebrand factor antigen, von Willebrand factor activity (ristocetin cofactor assay), von Willebrand factor collagen binding activity, factor II, factor V, factor VII, factor VIII, factor IX, factor X, factor XI, factor XII, factor XIII, Fletcher factor, Fitzgerald factor, circulating coagulation factor inhibitors other than by Bethesda assay - 1 test Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
65153	2 tests described in item 65150 Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00		
65156	3 or more tests described in item 65150 Fee: \$210.00 Benefit: 75% = \$157.50 85% = \$178.50		
65159	Quantitation of circulating coagulation factor inhibitors by Bethesda assay - 1 test Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50		
65162	Examination of a maternal blood film for the presence of fetal red blood cells (Kleihauer test) Fee: \$10.25 Benefit: 75% = \$7.70 85% = \$8.75		
65165	Detection and quantitation of fetal red blood cells in the maternal circulation by detection of red cell surface antigens using flow cytometric methods including (if performed) any test described in item 65070 or 65162 Fee: \$34.00 Benefit: 75% = \$25.50 85% = \$28.90		
65168	Characterisation of the genotype of a patient for Factor V Leiden gene mutation, or detection of other relevant mutations in the investigation of proven venous thrombosis or pulmonary embolism - 1 or more tests Fee: \$36.00 Benefit: 75% = \$27.00 85% = \$30.60		
65171	Test for the presence of antithrombin III deficiency, protein C deficiency, protein S deficiency or activated protein C resistance in a first degree relative of a person who has a proven defect of any of the above - 1 or more tests Fee: \$25.00 Benefit: 75% = \$18.75 85% = \$21.25		

PATHOLOGY		PATHOLOGY	
66174	Characterisation of the genotype of a person who is a first degree relative of a person who has been proven to have 1 or more abnormal genotypes under item 65168 - 1 or more tests Fee: \$36.00	Benefit: 75% = \$27.00	85% = \$30.60
GROUP P2 - CHEMICAL			
66500	Quantitation in serum, plasma, urine or other body fluid (except amniotic fluid), by any method except reagent tablet or reagent strip (with or without reflectance meter) of: acetoacetate, acid phosphatase, alanine aminotransferase, albumin, alkaline phosphatase, ammonia, amylase, aspartate aminotransferase, beta-hydroxybutyrate, bicarbonate, bilirubin (total), bilirubin (any fractions), C-reactive protein, calcium (total or corrected for albumin), chloride, creatine kinase, creatinine, gamma glutamyl transferase, globulin, glucose, lactate, lactate dehydrogenase, lipase, magnesium, phosphate, potassium, pyruvate, sodium, total protein, total cholesterol, triglycerides, urate or urea - 1 test Fee: \$9.45	Benefit: 75% = \$7.10	85% = \$8.05
66503	2 tests described in item 66500 Fee: \$11.40	Benefit: 75% = \$8.55	85% = \$9.70
66506	3 tests described in item 66500 Fee: \$13.35	Benefit: 75% = \$10.05	85% = \$11.35
66509	4 tests described in item 66500 Fee: \$15.30	Benefit: 75% = \$11.50	85% = \$13.05
66512	5 tests described in item 66500 Fee: \$17.25	Benefit: 75% = \$12.95	85% = \$14.70
66515	6 or more tests described in item 66500 Fee: \$19.20	Benefit: 75% = \$14.40	85% = \$16.35
66518	Investigation of cardiac or skeletal muscle damage by measurement of creatine kinase isoenzymes (by any method), troponin or myoglobin in plasma or serum - testing on 1 specimen in a 24 hour period Fee: \$19.80	Benefit: 75% = \$14.85	85% = \$16.85
66519	Investigation of cardiac or skeletal muscle damage by measurement of creatine kinase isoenzymes (by any method), troponin or myoglobin in plasma or serum - testing on 2 or more specimens in a 24 hour period Fee: \$39.60	Benefit: 75% = \$29.70	85% = \$33.70
66536	Quantitation of HDL cholesterol Fee: \$10.90	Benefit: 75% = \$8.20	85% = \$9.30
66539	Electrophoresis of serum for demonstration of lipoprotein subclasses, if the cholesterol is >6.5 mmol/L and triglyceride >4.0 mmol/L or in the diagnosis of types III and IV hyperlipidaemia - each episode to a maximum of 2 episodes in a 12 month period Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
66542	Oral glucose tolerance test for the diagnosis of diabetes mellitus that includes: (a) administration of glucose; and (b) at least 2 measurements of blood glucose; and (c) (if performed) any test described in item 66695 Fee: \$18.70	Benefit: 75% = \$14.05	85% = \$15.90
66545	Oral glucose challenge test in pregnancy for the detection of gestational diabetes that includes: (a) administration of glucose; and (b) 1 or 2 measurements of blood glucose; and (c) (if performed) any test in item 66695 Fee: \$15.60	Benefit: 75% = \$11.70	85% = \$13.30
66548	Oral glucose tolerance test in pregnancy for the diagnosis of gestational diabetes that includes: (a) administration of glucose; and (b) at least 3 measurements of blood glucose; and (c) any test in item 66695 (if performed) Fee: \$19.70	Benefit: 75% = \$14.80	85% = \$16.75
66551	Quantitation of glycosylated haemoglobin performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period Fee: \$16.60	Benefit: 75% = \$12.45	85% = \$14.15

66554	Quantitation of glycosylated haemoglobin performed in the management of pre-existing diabetes where the patient is pregnant - each test to a maximum of 6 tests in a 12 month period which includes the whole pregnancy, including a service in item 66551 (if performed) Fee: \$16.60	Benefit: 75% = \$12.45	85% = \$14.15
66557	Quantitation of fructosamine performed in the management of established diabetes - each test to a maximum of 4 tests in a 12 month period Fee: \$9.55	Benefit: 75% = \$7.20	85% = \$8.15
66560	Microalbumin - quantitation in urine Fee: \$19.90	Benefit: 75% = \$14.95	85% = \$16.95
66563	Osmolality, estimation by osmometer, in serum or in urine - 1 or more tests Fee: \$24.35	Benefit: 75% = \$18.30	85% = \$20.70
66566	Quantitation of: (a) blood gases (including pO ₂ , oxygen saturation and pCO ₂) ; and (b) bicarbonate and pH; including any other measurement (eg. haemoglobin, potassium or ionised calcium) or calculation performed on the same specimen - 1 or more tests on 1 specimen Fee: \$33.25	Benefit: 75% = \$24.95	85% = \$28.30
66569	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 2 specimens performed within any 1 day Fee: \$42.05	Benefit: 75% = \$31.55	85% = \$35.75
66572	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 3 specimens performed within any 1 day Fee: \$50.85	Benefit: 75% = \$38.15	85% = \$43.25
66575	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 4 specimens performed within any 1 day Fee: \$59.65	Benefit: 75% = \$44.75	85% = \$50.75
66578	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 5 specimens performed within any 1 day Fee: \$68.45	Benefit: 75% = \$51.35	85% = \$58.20
66581	Quantitation of blood gases, bicarbonate and pH as described in item 66566 on 6 or more specimens performed within any 1 day Fee: \$77.25	Benefit: 75% = \$57.95	85% = \$65.70
66584	Quantitation of ionised calcium (except if performed as part of item 66566) - 1 test Fee: \$9.55	Benefit: 75% = \$7.20	85% = \$8.15
66587	Urine acidification test for the diagnosis of renal tubular acidosis including the administration of an acid load, and pH measurements on 4 or more urine specimens and at least 1 blood specimen Fee: \$46.90	Benefit: 75% = \$35.20	85% = \$39.90
66590	Calculus, analysis of 1 or more Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
66593	Ferritin - quantitation, except if requested as part of iron studies Fee: \$17.80	Benefit: 75% = \$13.35	85% = \$15.15
66596	Iron studies, consisting of quantitation of: (a) serum iron; and (b) transferrin or iron binding capacity; and (c) ferritin Fee: \$32.10	Benefit: 75% = \$24.10	85% = \$27.30
66599	Serum B12 or red cell folate and, if required, serum folate (Item is subject to rule 21) Fee: \$23.35	Benefit: 75% = \$17.55	85% = \$19.85
66602	Serum B12 and red cell folate and, if required, serum folate (Item is subject to rule 21) Fee: \$42.45	Benefit: 75% = \$31.85	85% = \$36.10
66605	Vitamins - quantitation of vitamins A, B1, B2, B3, B6, C and E in blood, urine or other body fluid - 1 or more tests within a 6 month period Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70

PATHOLOGY		PATHOLOGY	
66653	2 or more tests described in item 66650 Fee: \$44.00	Benefit: 75% = \$33.00	85% = \$37.40
66655	Prostate specific antigen - quantitation - 1 patient episode in a 12 month period Fee: \$19.90	Benefit: 75% = \$14.95	85% = \$16.95
66656	Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease (including a test described in item 66655) Fee: \$19.90	Benefit: 75% = \$14.95	85% = \$16.95
66659	Prostate specific antigen - quantitation of 2 or more fractions of PSA and any derived index including (if performed) a test described in item 66656 , in the followup of a PSA result which lies in the equivocal range of the particular method of assay used to determine the level - 1 patient episode in a 12 month period Fee: \$36.65	Benefit: 75% = \$27.50	85% = \$31.20
66662	Quantitation of hormone receptors on proven primary breast or ovarian carcinoma or a metastasis from a breast or ovarian carcinoma or a subsequent lesion in the breast - 1 or more tests Fee: \$78.90	Benefit: 75% = \$59.20	85% = \$67.10
66665	Lead quantitation in blood or urine (other than for occupational health screening purposes) to a maximum of 3 tests in a 6 month period - each test Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
66667	Quantitation of serum zinc in a patient receiving intravenous alimentation - each test Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
66669	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 1 test to a maximum of 3 episodes in a 6 month period (Item is subject to rule 22) Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
66670	Quantitation of copper, manganese, selenium, or zinc (except if item 66667 applies), in blood, urine or other body fluid or tissue - 2 or more tests to a maximum of 3 episodes in a 6 month period (Item is subject to rule 22) Fee: \$51.75	Benefit: 75% = \$38.85	85% = \$44.00
66671	Quantitation of serum aluminium in a patient in a renal dialysis program - each test Fee: \$36.40	Benefit: 75% = \$27.30	85% = \$30.95
66672	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 1 test to a maximum of 3 episodes in a 6 month period (Item is subject to rule 22) Fee: \$30.20	Benefit: 75% = \$22.65	85% = \$25.70
66673	Quantitation of aluminium (except if item 66671 applies), arsenic, beryllium, cadmium, chromium, gold, mercury, nickel, or strontium, in blood, urine or other body fluid or tissue - 2 or more tests to a maximum of 3 episodes in a 6 month period (Item is subject to rule 22) Fee: \$51.75	Benefit: 75% = \$38.85	85% = \$44.00
66674	Quantitation of: (a) faecal fat; or (b) breath hydrogen in response to loading with disaccharides; 1 or more tests within a 28 day period Fee: \$39.45	Benefit: 75% = \$29.60	85% = \$33.55
66677	Test for tryptic activity in faeces in the investigation of diarrhoea of longer than 4 weeks duration in children under 6 years old Fee: \$11.00	Benefit: 75% = \$8.25	85% = \$9.35
66680	Quantitation of disaccharidases and other enzymes in intestinal tissue - 1 or more tests Fee: \$73.45	Benefit: 75% = \$55.10	85% = \$62.45
66683	Enzymes - quantitation in solid tissue or tissues other than blood elements or intestinal tissue - 1 or more tests Fee: \$73.45	Benefit: 75% = \$55.10	85% = \$62.45

PATHOLOGY		PATHOLOGY	
66686	<p>Performance of 1 or more of the following procedures:</p> <p>(a) growth hormone suppression by glucose loading;</p> <p>(b) growth hormone stimulation by exercise;</p> <p>(c) dexamethasone suppression test;</p> <p>(d) sweat collection by iontophoresis for chloride analysis;</p> <p>(e) pharmacological stimulation of growth hormone</p> <p>Fee: \$50.00 Benefit: 75% = \$37.50 85% = \$42.50</p>		
66689	<p>Personal performance by a recognised pathologist of 1 of the following procedures: (a) gonadotrophin releasing hormone stimulation test;</p> <p>(b) synacthen stimulation test;</p> <p>(c) glucagon stimulation test with C-peptide measurement;</p> <p>(d) pentagastrin or calcium stimulation of thyrocalcitonin release;</p> <p>(e) secretin or calcium stimulation of gastrin release;</p> <p>(f) insulin hypoglycaemia;</p> <p>(g) arginine infusion;</p> <p>(h) thyrotrophin releasing hormone (TRH) test</p> <p>Fee: \$80.00 Benefit: 75% = \$60.00 85% = \$68.00</p>		
66692	<p>Personal performance by a recognised pathologist of 2 or more tests described in item 66689</p> <p>Fee: \$140.00 Benefit: 75% = \$105.00 85% = \$119.00</p>		
66695	<p>Quantitation of hormones and hormone binding proteins - ACTH, aldosterone, androstenedione, C-peptide, calcitonin, cortisol, cyclic AMP, DHEAS, 11-deoxycortisol, dihydrotestosterone, FSH, gastrin, glucagon, growth hormone, hydroxyprogesterone, insulin, LH, oestradiol, oestrone, progesterone, prolactin, PTH, renin, sex hormone binding globulin, somatomedin C(IGF-1), free or total testosterone, urine steroid fraction or fractions, vasoactive intestinal peptide, vasopressin (antidiuretic hormone) - 1 test</p> <p>Fee: \$29.80 Benefit: 75% = \$22.35 85% = \$25.35</p>		
66698	<p>2 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 2 tests specified on the request form or performs 2 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p> <p>Fee: \$42.50 Benefit: 75% = \$31.90 85% = \$36.15</p>		
66701	<p>3 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 tests specified on the request form or performs 3 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p> <p>Fee: \$55.50 Benefit: 75% = \$41.65 85% = \$47.20</p>		
66704	<p>4 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 tests specified on the request form or performs 4 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p> <p>Fee: \$68.50 Benefit: 75% = \$51.40 85% = \$58.25</p>		
66707	<p>5 tests described in item 66695</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 tests specified on the request form or performs 5 tests and refers the rest to the laboratory of a separate APA)</p> <p>(Item is subject to rule 6)</p> <p>Fee: \$81.50 Benefit: 75% = \$61.15 85% = \$69.30</p>		
66710	<p>6 or more tests described in item 66695</p> <p>(Item is subject to rule 6)</p> <p>Fee: \$94.50 Benefit: 75% = \$70.90 85% = \$80.35</p>		
66713	<p>Tests described in item 66695, if rendered under a request referred to in subparagraph (2)(a)(iii) of rule 6 - each test to a maximum of 5 tests</p> <p>(Item is subject to rule 6)</p> <p>Fee: \$13.00 Benefit: 75% = \$9.75 85% = \$11.05</p>		
66716	<p>TSH quantitation</p> <p>Fee: \$24.70 Benefit: 75% = \$18.55 85% = \$21.00</p>		

PATHOLOGY		PATHOLOGY	
66749	Amniotic fluid, spectrophotometric examination of, and quantitation of: (a) lecithin/sphingomyelin ratio; or (b) palmitic acid, phosphatidylglycerol or lamellar body phospholipid; or (c) bilirubin, including correction for haemoglobin 1 or more tests Fee: \$32.50	Benefit: 75% = \$24.40	85% = \$27.65
66752	Quantitation of citrate, oxalate, total free fatty acids or amino acids including cysteine, homocysteine, cystine and hydroxyproline (except if performed as part of item 66773 or 66776) - 1 test Fee: \$24.35	Benefit: 75% = \$18.30	85% = \$20.70
66755	2 or more tests described in item 66752 Fee: \$38.30	Benefit: 75% = \$28.75	85% = \$32.60
66758	Quantitation of angiotensin converting enzyme, or cholinesterase - 1 or more tests Fee: \$24.35	Benefit: 75% = \$18.30	85% = \$20.70
66761	Test for reducing substances in faeces by any method (except reagent strip or dipstick) Fee: \$13.00	Benefit: 75% = \$9.75	85% = \$11.05
66764	Examination for faecal occult blood (including tests for haemoglobin and its derivatives in the faeces) by: (a) an immunological method; and (b) a chemical method (except reagent strip or dip stick); with a maximum of 3 examinations on specimens collected on separate days in a 28 day period - 1 examination by both methods (See para PP , of explanatory notes to this Category) Fee: \$8.80	Benefit: 75% = \$6.60	85% = \$7.50
66767	2 examinations by both methods described in item 66764 performed on separately collected and identified specimens Fee: \$17.60	Benefit: 75% = \$13.20	85% = \$15.00
66770	3 examinations by both methods described in item 66764 performed on separately collected and identified specimens Fee: \$26.40	Benefit: 75% = \$19.80	85% = \$22.45
66773	Quantitation of products of collagen breakdown for the monitoring of patients with proven low bone mineral density, and if performed, a service described in item 66752 - 1 or more tests (Low bone densitometry is defined in paragraph D1.18 of explanatory notes to Category 2 - Diagnostic Procedures and Investigations of the Medicare Benefits Schedule) Fee: \$24.35	Benefit: 75% = \$18.30	85% = \$20.70
66776	Quantitation of products of collagen breakdown for the monitoring of patients with metabolic bone disease or Paget's disease of bone, and if performed, a service described in item 66752 - 1 or more tests Fee: \$24.35	Benefit: 75% = \$18.30	85% = \$20.70
66779	Adrenaline, noradrenaline, dopamine, histamine, hydroxyindoleacetic acid (SHIAA), hydroxymethoxymandelic acid (HMMA), homovanillic acid (HVA), metanephrines, methoxyhydroxyphenylethylene glycol (MHPG), phenylacetic acid (PAA) or serotonin quantitation - 1 or more tests Fee: \$39.45	Benefit: 75% = \$29.60	85% = \$33.55
66782	Porphyryns or porphyryns precursors - detection in plasma, red cells, urine or faeces - 1 or more tests Fee: \$13.00	Benefit: 75% = \$9.75	85% = \$11.05
66785	Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 1 test Fee: \$39.45	Benefit: 75% = \$29.60	85% = \$33.55
66788	Porphyryns or porphyryns precursors - quantitation in plasma, red cells, urine or faeces - 2 or more tests Fee: \$65.00	Benefit: 75% = \$48.75	85% = \$55.25
66791	Porphyryn biosynthetic enzymes - measurement of activity in blood cells or other tissues - 1 or more tests Fee: \$73.45	Benefit: 75% = \$55.10	85% = \$62.45

PATHOLOGY	PATHOLOGY
66794	<p>Detection of the C282Y genetic mutation of the HFE gene and, if performed, detection of other mutations for haemochromatosis where:</p> <p>(a) the patient has an elevated transferrin saturation or elevated serum ferritin on testing of repeated specimens; or</p> <p>(b) the patient has a first degree relative with haemochromatosis; or</p> <p>(c) the patient has a first degree relative with homozygosity for the C282Y genetic mutation, or with compound heterozygosity for recognised genetic mutations for haemochromatosis (Item is subject to rule 20)</p> <p>Fee: \$36.00 Benefit: 75% = \$27.00 85% = \$30.60</p>
GROUP P3 - MICROBIOLOGY	
69300	<p>Microscopy of wet film material other than blood, from 1 or more sites, obtained directly from a patient (not cultures) including: (a) differential cell count (if performed); or</p> <p>(b) examination for dermatophytes; or</p> <p>(c) dark ground illumination; or</p> <p>(d) stained preparation or preparations using any relevant stain or stains; 1 or more tests</p> <p>Fee: \$12.20 Benefit: 75% = \$9.15 85% = \$10.40</p>
69303	<p>Culture and (if performed) microscopy to detect pathogenic micro-organisms (including fungi but excluding viruses) from nasal swabs, throat swabs, eye swabs and ear swabs (excluding swabs taken for epidemiological surveillance), including (if performed):</p> <p>(a) pathogen identification and antibiotic susceptibility testing; or</p> <p>(b) the detection of antigens not elsewhere described in this Table; or</p> <p>(c) a service described in item 69300;</p> <p>specimens from 1 or more sites</p> <p>Fee: \$21.50 Benefit: 75% = \$16.15 85% = \$18.30</p>
69306	<p>Microscopy and culture to detect pathogenic micro-organisms (including fungi but excluding viruses) from skin or other superficial sites, including (if performed):</p> <p>(a) the detection of antigens not elsewhere specified in this Table; or</p> <p>(b) pathogen identification and antibiotic susceptibility testing; or</p> <p>(c) a service described in items 69300, 69303, 69312, 69318 and 73810; 1 or more tests on 1 or more specimens</p> <p>Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>
69309	<p>Microscopy and culture to detect dermatophytes and other fungi causing cutaneous disease from skin scrapings, skin biopsies, hair and nails (excluding swab specimens) and including (if performed):</p> <p>(a) the detection of antigens not elsewhere specified in this Table; or</p> <p>(b) a service described in items 69300, 69303, 69306, 69312, 69318 and 73810; 1 or more tests on 1 or more specimens</p> <p>Fee: \$47.00 Benefit: 75% = \$35.25 85% = \$39.95</p>
69312	<p>Microscopy and culture to detect pathogenic micro-organisms (including fungi but excluding viruses) from urethra, vagina, cervix or rectum (except for faecal pathogens), including (if performed):</p> <p>(a) the detection of antigens not elsewhere specified in this Table; or</p> <p>(b) pathogen identification and antibiotic susceptibility testing; or</p> <p>(c) a service described in items 69300, 69303, 69306 and 69318; 1 or more tests on 1 or more specimens</p> <p>Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>
69315	<p>Microscopy and culture to detect pathogenic micro-organisms, and the detection of chlamydia from urethra, vagina, cervix or rectum and including (if performed):</p> <p>(a) the detection of microbial antigens; or</p> <p>(b) pathogen identification and antibiotic susceptibility testing; or</p> <p>(c) a service described in item 69300, 69303, 69306, 69312, 69318, 69363, 69369, 69370, 69372, 69375 or 73810; 1 or more tests on 1 or more specimens</p> <p>Fee: \$64.00 Benefit: 75% = \$48.00 85% = \$54.40</p>
69318	<p>Microscopy and culture to detect pathogenic micro-organisms (including fungi but excluding viruses) from specimens of sputum (except when part of items 69324, 69327 and 69330), including (if performed):</p> <p>(a) the detection of antigens not elsewhere specified in this Table; or</p> <p>(b) pathogen identification and antibiotic susceptibility testing; or</p> <p>(c) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens</p> <p>Fee: \$33.00 Benefit: 75% = \$24.75 85% = \$28.05</p>

69390	<p>3 tests described in item 69384</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 3 estimations specified on the request form or performs 3 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)</p> <p>Fee: \$42.00 Benefit: 75% = \$31.50 85% = \$35.70</p>
69393	<p>4 tests described in item 69384</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 4 estimations specified on the request form or performs 4 of the antibody estimations specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)</p> <p>Fee: \$56.00 Benefit: 75% = \$42.00 85% = \$47.60</p>
69396	<p>5 tests described in item 69384</p> <p>(This fee applies where 1 laboratory, or more than 1 laboratory belonging to the same APA, performs the only 5 estimations specified on the request form or performs 5 of the antibody tests specified on the request form and refers the remainder to the laboratory of a separate APA) (Item is subject to rule 6)</p> <p>Fee: \$70.00 Benefit: 75% = \$52.50 85% = \$59.50</p>
69399	<p>6 or more tests described in item 69384</p> <p>Fee: \$84.00 Benefit: 75% = \$63.00 85% = \$71.40</p>
69402	<p>Tests described in item 69384, if rendered under a request referred to in subparagraph (2) (a) (iii) of rule 6 - each test to a maximum of 5 tests (Item is subject to rule 6)</p> <p>Fee: \$14.00 Benefit: 75% = \$10.50 85% = \$11.90</p>
69405	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 1 of the following - rubella immune status, specific syphilis serology, Hepatitis B surface antigen; and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478, 69481, 69484, 69487, 69490 and 69493</p> <p>Fee: \$15.30 Benefit: 75% = \$11.50 85% = \$13.05</p>
69408	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of 2 of the following - rubella immune status, specific syphilis serology, Hepatitis B surface antigen; and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478, 69481, 69484, 69487, 69490 and 69493</p> <p>Fee: \$27.15 Benefit: 75% = \$20.40 85% = \$23.10</p>
69411	<p>Microbiological serology during a pregnancy (except in the investigation of a clinically apparent intercurrent microbial illness or close contact with a patient suffering from parvovirus infection or varicella during that pregnancy) including:</p> <p>(a) the determination of all 3 of the following - rubella immune status, specific syphilis serology, Hepatitis B surface antigen; and</p> <p>(b) (if performed) a service described in 1 or more of items 69384, 69475, 69478, 69481, 69484, 69487, 69490 and 69493</p> <p>Fee: \$38.15 Benefit: 75% = \$28.65 85% = \$32.45</p>
69442	<p>Quantitation of HCV RNA load in plasma or serum in the pretreatment evaluation for antiviral therapy of a patient with chronic HCV hepatitis - where any request for the test is made by or on the advice of the specialist or consultant physician who manages the treatment of the patient with chronic HCV hepatitis (including a service in item 69444 or 69445) - not exceeding 1 episode in a 12 month period (Item is subject to rule 19)</p> <p>Fee: \$176.00 Benefit: 75% = \$132.00 85% = \$149.60</p>
69443	<p>Nucleic acid amplification and determination of Hepatitis C virus (HCV) genotype if: (a) the patient is HCV RNA positive and is being evaluated for antiviral therapy of chronic HCV hepatitis; and (b) the request for the test is made by, or on the advice of, the specialist or consultant physician managing the treatment of the patient; No more than 1 episode in a 12 month period</p> <p>Fee: \$200.00 Benefit: 75% = \$150.00 85% = \$170.00</p>

PATHOLOGY		PATHOLOGY	
69444	<p>Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive and has normal liver function tests on 2 occasions at least 6 months apart;</p> <p>(b) the patient's serological status is uncertain after testing;</p> <p>(c) the test is performed for the purpose of:</p> <p>(i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or</p> <p>(ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient;</p> <p>Not exceeding 1 episode in a 12 month period (Item is subject to rule 19)</p>	<p>Fee: \$90.00</p> <p>Benefit: 75% = \$67.50 85% = \$76.50</p>	
69445	<p>Detection of Hepatitis C viral RNA in a patient undertaking antiviral therapy for chronic HCV hepatitis (including a service described in item 69444) - not exceeding 4 episodes in a 12 month period (Item is subject to rule 19)</p>	<p>Fee: \$90.00</p> <p>Benefit: 75% = \$67.50 85% = \$76.50</p>	
69471	<p>Test of cell-mediated immunity in blood for the detection of active tuberculosis or atypical mycobacterial infection in an immunosuppressed or immunocompromised patient - 1 test</p>	<p>Fee: \$34.10</p> <p>Benefit: 75% = \$25.60 85% = \$29.00</p>	
69472	<p>Detection of antibodies to Epstein Barr Virus using specific serology - 1 test</p>	<p>Fee: \$15.30</p> <p>Benefit: 75% = \$11.50 85% = \$13.05</p>	
69474	<p>Detection of antibodies to Epstein Barr Virus using specific serology - 2 or more tests</p>	<p>Fee: \$28.00</p> <p>Benefit: 75% = \$21.00 85% = \$23.80</p>	
69475	<p>One test for hepatitis antigen or antibodies to determine immune status or viral carriage following exposure or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D including:</p> <p>(a) One test for antibodies to Hepatitis A; or</p> <p>(b) One test for antibodies to or antigens of Hepatitis B; or</p> <p>(c) One test for antibodies to Hepatitis C; or</p> <p>(d) One test for antibodies to Hepatitis D in a patient who is Hepatitis B surface antigen positive (Item subject to rule 11)</p>	<p>Fee: \$15.30</p> <p>Benefit: 75% = \$11.50 85% = \$13.05</p>	
69478	<p>Two tests for hepatitis antigens or antibodies to determine immune status or viral carriage following exposure to, or vaccination to Hepatitis A, Hepatitis B, Hepatitis C or Hepatitis D including:</p> <p>(a) One test for antibodies to Hepatitis A; or</p> <p>(b) One test for surface or core antibodies to Hepatitis B; or</p> <p>(c) One test for surface antigen of Hepatitis B; or</p> <p>(d) One test for 'e' antibodies to or 'e' antigen of Hepatitis B; or</p> <p>(e) One test for antibodies to Hepatitis C; or</p> <p>(f) One test for antibodies to Hepatitis D in a patient who is Hepatitis B surface antigen positive (Item subject to rule 11)</p>	<p>Fee: \$28.55</p> <p>Benefit: 75% = \$21.45 85% = \$24.30</p>	
69481	<p>Three tests for the investigation of infectious causes of acute or chronic hepatitis including: (a) One test for antibodies to Hepatitis A; or</p> <p>(b) One test for core antibodies to Hepatitis B; or</p> <p>(c) One test for 'e' antibodies to or 'e' antigens of Hepatitis B; or</p> <p>(d) One test for surface antibodies to or surface antigen of Hepatitis B; or</p> <p>(e) One test for antibodies to Hepatitis C; or</p> <p>(f) One test for antibodies to Hepatitis D in a patient who is Hepatitis B surface antigen positive (Item subject to rule 11)</p>	<p>Fee: \$39.55</p> <p>Benefit: 75% = \$29.70 85% = \$33.65</p>	
69484	<p>Supplementary testing for Hepatitis B surface antigen or Hepatitis C antibody using a different assay on the specimen which yielded a reactive result on initial testing (Item is not subject to rule 11)</p>	<p>Fee: \$16.70</p> <p>Benefit: 75% = \$12.55 85% = \$14.20</p>	
69487	<p>One test referred to in 69475 and a supplementary test described in 69484 (Item subject to rule 11)</p>	<p>Fee: \$32.00</p> <p>Benefit: 75% = \$24.00 85% = \$27.20</p>	

PATHOLOGY		PATHOLOGY	
69490	Two tests referred to in 69478 and a supplementary test described in 69484 (Item subject to rule 11) Fee: \$45.25	Benefit: 75% = \$33.95	85% = \$38.50
69493	Three tests referred to in 69481 and a supplementary test described in 69484 (Item subject to rule 11) Fee: \$56.25	Benefit: 75% = \$42.20	85% = \$47.85
GROUP P4 - IMMUNOLOGY			
71057	Electrophoresis, quantitative and qualitative, of serum, urine or other body fluid all collected within a 28 day period, to demonstrate: (a) protein classes; or (b) presence and amount of paraprotein; including the preliminary quantitation of total protein, albumin and globulin - 1 specimen type Fee: \$35.20	Benefit: 75% = \$26.40	85% = \$29.95
71058	Examination as described in item 71057 of 2 or more specimen types Fee: \$49.85	Benefit: 75% = \$37.40	85% = \$42.40
71059	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of: (a) urine for detection of Bence Jones proteins; or (b) serum, plasma or other body fluid; and characterisation, if detected, of a paraprotein or cryoglobulin not previously characterised - examination of 1 specimen type (eg. serum, urine or CSF) Fee: \$28.80	Benefit: 75% = \$21.60	85% = \$24.50
71060	Examination as described in item 71059 of 2 or more specimen types Fee: \$43.45	Benefit: 75% = \$32.60	85% = \$36.95
71062	Electrophoresis and immunofixation or immunoelectrophoresis or isoelectric focussing of CSF for the detection of oligoclonal bands and including if required electrophoresis of the patient's serum for comparison purposes - 1 or more tests Fee: \$43.45	Benefit: 75% = \$32.60	85% = \$36.95
71064	Detection and quantitation of cryoglobulins or cryofibrinogen - 1 or more tests Fee: \$20.45	Benefit: 75% = \$15.35	85% = \$17.40
71066	Quantitation of total immunoglobulin A by any method in serum, urine or other body fluid - 1 test Fee: \$14.35	Benefit: 75% = \$10.80	85% = \$12.20
71068	Quantitation of total immunoglobulin G by any method in serum, urine or other body fluid - 1 test Fee: \$14.35	Benefit: 75% = \$10.80	85% = \$12.20
71069	2 tests described in items 71066 , 71068 , 71072 or 71074 Fee: \$22.45	Benefit: 75% = \$16.85	85% = \$19.10
71071	3 or more tests described in items 71066 , 71068 , 71072 or 71074 Fee: \$30.55	Benefit: 75% = \$22.95	85% = \$26.00
71072	Quantitation of total immunoglobulin M by any method in serum, urine or other body fluid - 1 test Fee: \$14.35	Benefit: 75% = \$10.80	85% = \$12.20
71073	Quantitation of all 4 immunoglobulin G subclasses - each patient episode Fee: \$104.75	Benefit: 75% = \$78.60	85% = \$89.05
71074	Quantitation of total immunoglobulin D by any method in serum, urine or other body fluid - 1 test Fee: \$14.35	Benefit: 75% = \$10.80	85% = \$12.20
71075	Quantitation of immunoglobulin E (total), with a maximum of 2 patient episodes in any 12 month period - each patient episode Fee: \$22.70	Benefit: 75% = \$17.05	85% = \$19.30
71077	Quantitation of immunoglobulin E (total) in the follow up of a patient with proven immunoglobulin-E-secreting myeloma, proven congenital immunodeficiency or proven allergic bronchopulmonary aspergillosis, with a maximum of 6 patient episodes in a 12 month period - each patient episode Fee: \$26.70	Benefit: 75% = \$20.05	85% = \$22.70

71151	Tissue typing for HLA-DR, HLA-DP and HLA-DQ Class II antigens (including any separation of leucocytes) - phenotyping or genotyping of 2 or more antigens Fee: \$117.30 Benefit: 75% = \$88.00 85% = \$99.75
71153	Investigations in the assessment or diagnosis of systemic inflammatory disease or vasculitis - antineutrophil cytoplasmic antibody immunofluorescence (ANCA test), antineutrophil proteinase 3 antibody (PR-3 ANCA test), antimyeloperoxidase antibody (MPO ANCA test) or antiglomerular basement membrane antibody (GBM test) - detection of 1 antibody (Item is subject to rule 23) Fee: \$34.10 Benefit: 75% = \$25.60 85% = \$29.00
71155	Detection of 2 antibodies described in item 71153 (Item is subject to rule 23) Fee: \$46.80 Benefit: 75% = \$35.10 85% = \$39.80
71157	Detection of 3 antibodies described in item 71153 (Item is subject to rule 23) Fee: \$59.50 Benefit: 75% = \$44.65 85% = \$50.60
71159	Detection of 4 or more antibodies described in item 71153 (Item is subject to rule 23) Fee: \$72.20 Benefit: 75% = \$54.15 85% = \$61.40
71160	Detection of antibodies for the monitoring of established coeliac disease or other gluten hypersensitivity syndromes, including: a) IgA antibody to gliadin; or b) IgG antibody to gliadin; or c) Antibody to endomysium; or d) Antibody to tissue transglutaminase; or e) IgA antibody to tissue transglutaminase; or f) IgG antibody to tissue transglutaminase One test Fee: \$34.10 Benefit: 75% = \$25.60 85% = \$29.00
71161	Two or more tests described in 71160 for the monitoring of established coeliac disease or other gluten hypersensitivity syndrome Fee: \$46.80 Benefit: 75% = \$35.10 85% = \$39.80
71162	Three or more tests described in 71160 for the diagnosis of coeliac disease or other gluten hypersensitivity syndrome. To a maximum of 2 patient episodes in a 12 month period - each patient episode (Item subject to rule 24) Fee: \$50.20 Benefit: 75% = \$37.65 85% = \$42.70

PATHOLOGY		PATHOLOGY	
GROUP P5 - TISSUE PATHOLOGY			
72813	Examination of complexity level 2 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) Fee: \$70.00	Benefit: 75% = \$52.50	85% = \$59.50
72816	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) Fee: \$84.50	Benefit: 75% = \$63.40	85% = \$71.85
72817	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) Fee: \$94.50	Benefit: 75% = \$70.90	85% = \$80.35
72818	Examination of complexity level 3 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 or more separately identified specimens (Item is subject to rule 13) Fee: \$104.50	Benefit: 75% = \$78.40	85% = \$88.85
72823	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 separately identified specimen (Item is subject to rule 13) Fee: \$95.00	Benefit: 75% = \$71.25	85% = \$80.75
72824	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 2 to 4 separately identified specimens (Item is subject to rule 13) Fee: \$138.00	Benefit: 75% = \$103.50	85% = \$117.30
72825	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 5 to 7 separately identified specimens (Item is subject to rule 13) Fee: \$176.00	Benefit: 75% = \$132.00	85% = \$149.60
72826	Examination of complexity level 4 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 8 or more separately identified specimens (Item is subject to rule 13) Fee: \$190.00	Benefit: 75% = \$142.50	85% = \$161.50
+ 72830	Examination of complexity level 5 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) Fee: \$185.00	Benefit: 75% = \$138.75	85% = \$157.25
+ 72836	Examination of complexity level 6 biopsy material with 1 or more tissue blocks, including specimen dissection, all tissue processing, staining, light microscopy and professional opinion or opinions - 1 or more separately identified specimens (Item is subject to rule 13) Fee: \$285.00	Benefit: 75% = \$213.75	85% = \$242.25
72844	Enzyme histochemistry of skeletal muscle for investigation of primary degenerative or metabolic muscle diseases or of muscle abnormalities secondary to disease of the central or peripheral nervous system - 1 or more tests Fee: \$30.00	Benefit: 75% = \$22.50	85% = \$25.50

PATHOLOGY	PATHOLOGY
GROUP P6 - CYTOLOGY	
73043	<p>Cytology (including serial examinations) of nipple discharge or smears from skin, lip, mouth, nose or anus for detection of precancerous or cancerous changes 1 or more tests Fee: \$22.30 Benefit: 75% = \$16.75 85% = \$19.00</p>
73045	<p>Cytology (including serial examinations) for malignancy (other than an examination mentioned in item 73053); and including any Group P5 service, if performed on: (a) specimens resulting from washings or brushings from sites not specified in item 73043; or (b) a single specimen of sputum or urine; or (c) 1 or more specimens of other body fluids; 1 or more tests Fee: \$47.50 Benefit: 75% = \$35.65 85% = \$40.40</p>
73047	<p>Cytology of a series of 3 sputum or urine specimens for malignant cells Fee: \$92.50 Benefit: 75% = \$69.40 85% = \$78.65</p>
73049	<p>Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues Fee: \$67.50 Benefit: 75% = \$50.65 85% = \$57.40</p>
73051	<p>Cytology of material obtained directly from a patient by fine needle aspiration of solid tissue or tissues if: (a) the aspiration is performed by a recognised pathologist; or (b) a recognised pathologist attends the aspiration and performs cytological examination during the attendance Fee: \$166.35 Benefit: 75% = \$124.80 85% = \$141.40</p>
73053	<p>Cytology of a smear from cervix where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each examination (a) for the detection of precancerous or cancerous changes in women with no symptoms, signs or recent history suggestive of cervical neoplasia, or (b) if a further specimen is taken due to an unsatisfactory smear taken for the purposes of paragraph (a); or (c) if there is inadequate information provided to use item 73055; <i>(See para PP, of explanatory notes to this Category)</i> Fee: \$19.00 Benefit: 75% = \$14.25 85% = \$16.15</p>
73055	<p>Cytology of a smear from cervix, not associated with item 73053, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test (a) for the management of previously detected abnormalities including precancerous or cancerous conditions; or (b) for the investigation of women with symptoms, signs or recent history suggestive of cervical neoplasia; <i>(See para PP, of explanatory notes to this Category)</i> Fee: \$19.00 Benefit: 75% = \$14.25 85% = \$16.15</p>
73057	<p>Cytology of smears from vagina, not associated with item 73053 or 73055 and not to monitor hormone replacement therapy, where the smear is prepared by direct application of the specimen to a slide, excluding the use of liquid based slide preparation techniques, and the stained smear is microscopically examined by or on behalf of a pathologist - each test <i>(See para PP, of explanatory notes to this Category)</i> Fee: \$19.00 Benefit: 75% = \$14.25 85% = \$16.15</p>
73059	<p>Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 1 to 3 antibodies Fee: \$42.00 Benefit: 75% = \$31.50 85% = \$35.70</p>
73060	<p>Immunocytochemical examination of material obtained by procedures described in items 73045, 73047, 73049 and 73051 for the characterisation of a malignancy by immunofluorescence, immunoperoxidase or other labelled antibody techniques with multiple antigenic specificities per specimen - 4 or more antibodies Fee: \$56.00 Benefit: 75% = \$42.00 85% = \$47.60</p>

PATHOLOGY	PATHOLOGY
GROUP P7 - CYTOGENETICS	
73287	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or fragile X-site determination of 1 or more of any tissue or fluid except blood - 1 or more tests Fee: \$354.00 Benefit: 75% = \$265.50 85% = \$300.90
73289	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques or fragile X-site determination of blood - 1 or more tests Fee: \$322.00 Benefit: 75% = \$241.50 85% = \$273.70

PATHOLOGY	PATHOLOGY
GROUP P9 - SIMPLE BASIC PATHOLOGY TESTS	
73801	Semen examination for presence of spermatozoa Fee: \$6.75 Benefit: 75% = \$5.10 85% = \$5.75
73802	Leucocyte count, erythrocyte sedimentation rate, examination of blood film (including differential leucocyte count), haemoglobin, haematocrit or erythrocyte count - 1 test Fee: \$4.45 Benefit: 75% = \$3.35 85% = \$3.80
73803	2 tests described in item 73802 Fee: \$6.20 Benefit: 75% = \$4.65 85% = \$5.30
73804	3 or more tests described in item 73802 Fee: \$7.95 Benefit: 75% = \$6.00 85% = \$6.80
73805	Microscopy of urine, whether stained or not, or catalase test Fee: \$4.45 Benefit: 75% = \$3.35 85% = \$3.80
73806	Pregnancy test by 1 or more immunochemical methods Fee: \$9.90 Benefit: 75% = \$7.45 85% = \$8.45
73807	Microscopy for wet film other than urine, including any relevant stain Fee: \$6.75 Benefit: 75% = \$5.10 85% = \$5.75
73808	Microscopy of Gram-stained film, including (if performed) a service described in item 73805 or 73807 Fee: \$8.45 Benefit: 75% = \$6.35 85% = \$7.20
73809	Chemical tests for occult blood in faeces by reagent stick, strip, tablet or similar method Fee: \$2.30 Benefit: 75% = \$1.75 85% = \$2.00
73810	Microscopy for fungi in skin, hair or nails - 1 or more sites Fee: \$6.75 Benefit: 75% = \$5.10 85% = \$5.75
73811	Mantoux test Fee: \$10.95 Benefit: 75% = \$8.25 85% = \$9.35

**INDEX TO
PATHOLOGY SERVICES
(ABBREVIATIONS)**



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Acetoacetate	ACAT	66500
Acetylcholine receptor - tissue antigens - antibodies	ARA	71109
Actinomycetes - microbial antibody testing	ACT	69384
Activated Protein C resistance	APC	65132-65136, 65142, 65171
Adenovirus - microbial antibody testing	ADE	69384
Adrenal cortex - tissue antigens - antibodies	ADR	71109
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Borrelia burgdorferi - microbial antibody testing	BOB	69384
Breath hydrogen test	BHT	66674
Bromide	BRMD	66611
Brucella - microbial antibody testing	BRU	69384
C-I esterase inhibitor - functional	CEIF	66647
C-I esterase inhibitor - quantitation	CEIQ	66644
CA-125 antigen	C125	66650
CA-15.3 antigen	CA15	66650
CA-19.9 antigen	CA19	66650
Cadmium	CD	66672-66673
Caeruloplasmin	CPLS	66632
Calcitonin	CALT	66695
Calcium - ionised	ICA	66584
Calcium (total or corrected for albumin)	CA	66500
Calculus analysis	CALC	66590
Campylobacter jejuni - microbial antibody testing	CAM	69384
Candida - microbial antibody testing	CAN	69384
Carbamazepine (Tegretol)	CARB	66611
Carboxyhaemoglobin	COHB	65117
Carcinoembryonic antigen	CEA	66650
Cardiac enzymes (see test groups at para PQ.4)	CE	66506
Cardiolipin - tissue antigens - antibodies	ACL	71109
Catecholamines	CAT	66779
Cell mediated immunity - delayed type - hypersensitivity test	CMI	71137
Cell-mediated immunity in blood	CMIB	69471
Cervix - cytology - abnormalities	CCRA	73055
Cervix - cytology - routine	CCR	73053
Cervix - microscopy & culture of material from	MCGR	69312
Cervix - microscopy & culture of material from	MCCH	69315
Characterisation of antibodies if positive ENA	ENAP	71103
Chemicals, toxic (ingested or absorbed) - assays	DRGO	66623
Chlamydia by any method and N. gonorrhoea by NAA methods	CHGO	69370
Chlamydia - investigation by any method	CHLM	69369
Chlamydia - microbial antibody testing	CHL	69384
Chlamydia - microbial antigen testing	MCCH	69315, 69369
Chloral hydrate	CHHY	66611
Chlorazepate	CHZP	66611
Chloride	CL	66500
Chloroquine	CLOQ	66611
Chlorpromazine	CHLO	66611
Cholesterol	CHOL	66500
Cholesterol - HDL	HDLC	66536
Cholinesterase	CHSE	66758
Chorionic gonadotrophin - quantitation	HCG	66650-66653, 66740, 73529
Chorionic gonadotrophin - detection for pregnancy diagnosis	HCGP	73527-73529
Chromium	CR	66672-66673
Chromosome identification - studies - blood	CSB	73289
Chromosome identification - studies - other than blood	CS	73287
Chromosome identification and banding		73287-73289
Cimetidine	CMTD	66611
Clobazam	CLOB	66611
Clomipramine	CLOM	66611
Clonazepam (Rivotril)	CLON	66611
Clostridium difficile - microbial antigen testing	CLDT	69363
Coagulation factor inhibitors by Bethesda assay	BETH	65159
Coagulation - factors (see individual factors)		
Coagulation - studies (see test groups at para PQ.4)	COAG	65120
Coccidioides - microbial antibody testing	CCC	69384

Coeliac antibodies	CLC	71160-71162 ,
Cold agglutinins	CAG	65114
Collagen - low bone	CBLB	66773
Collagen - metabolic disease	CBMB	66776
Compatibility testing	XMAT	65099-65108
Complement, total haemolytic	COM	71081
Complement, total haemolytic - components C3	C3	71083
Complement, total haemolytic - components C4	C4	71083
Complement, total haemolytic - other components	COMP	71089
Complement, total haemolytic - properdin factor B	PFB	71083
Copper	CU	66669-66670
Cortisol	CORT	66695
Coxsackie B1-6 - microbial antibody testing	COX	69384
C-Peptide	CPEP	66695
C-reactive protein	CRP	66500
Creatine kinase	CK	66500
Creatine kinase - isoenzymes	CKI	66518
Creatine kinase - isoenzymes (electrophoresis)	CKIE	66518
Creatinine	C	66500
Cryofibrinogen - detection and quantitation	CFID	71064
Cryoglobulins - characterisation by electrophoresis, and immunoelectrophoresis or immunofixation or isoelectric focussing	RYO	71059
Cryoglobulins - detection and quantitation	CGLD	71064
Cryptococcal antigen - microbial antigen testing	CRYN	69372
Cryptococcus - microbial antibody testing	CRY	69384
CSF - microscopy & culture of material from	MCPO	69321
CSF antigens - group B streptococcus	STB	69372
CSF antigens - Haemophilus influenzae	HI	69372
CSF antigens - Neisseria meningitidis	NMG	69372
CSF antigens - Streptococcus pneumoniae	SPN	69372
Cultural examination of faeces	FCS	69345-69351
Cyclic AMP	CAMP	66695
Cyclosporin A	CLSA	66611
Cystine - qualitative	UCYS	66752
Cystine - quantitative	CYST	66752
Cytology - fine needle aspiration of solid tissues	FNCY	73049
Cytology - fine needle aspiration of solid tissues - aspiration or attendance by a pathologist	FNCP	73051
Cytology - from 3 sputum or urine specimens	SPCY	73047
Cytology - from body fluids, sputum (1 specimen), urine, washings or brushings	BFCY	73045
Cytology - from cervix - abnormalities	CCRA	73055
Cytology - from cervix - routine	CCR	73053
Cytology - from skin, nipple discharge, lip, mouth, nose or anus	SMCY	73043
Cytology - from vagina	CVO	73057
Cytomegalovirus - microbial antibody testing	CMV	69384
Cytomegalovirus serology in pregnancy - microbial antibody testing	CMVP	69405-69411
D vitamin	VITD	66608
D-dimer test	DD	65120
Dehydroepiandrosterone sulphate (DHEAS)	DHEA	66695
Dengue - microbial antibody testing	DEN	69384
11 - Deoxycortisol	DCOR	66695
Desipramine	DESI	66611
Dexamethasone	DXST	66686
Dexamethasone - suppression test	DEXA	66686
DHEAS (Dehydroepiandrosterone sulphate)	DHEA	66695
Diazepam	DIAZ	66611
Differential cell count	DIFF	65070
Digoxin	DIG	66611
Dihydrotestosterone	DHTS	66695
Diphenylhydantoin (Dilantin)	DIL	66611

Diphtheria - microbial antibody testing	DIP	69384
Direct Coombs test	CMBS	65114
Disopyramide (Rythmodan)	DISO	66611
DNA binding - quantitation & measurement if positive ANA	ANAP	71099
DNA, (double-stranded DNA) antibody	DSDNA	71099
Donath Landsteiner antibody test	DLAT	65075
Down's syndrome and neural tube defects (see test groups at para PQ.4)	NTDD	66740
Doxepin hydrochloride	DOXE	66611
Drugs - abuse treatment programme - assay	DATP	66626
Drugs - inappropriate dosage - assay	DRGO	66623
Drugs - therapeutic - assay (See individual drugs)		66611
Drugs not listed must be written in full		
Dynamic function tests	GHSE	66686
Ear - microscopy & culture of material from	MCSW	69303
Echinococcus - microbial antibody testing	ECC	69384
Echis test	ECHI	65120
ECHO-Coxsackie group - microbial antibody testing	ECH	69384
Electrolytes (see test groups at para PQ.4)	E	66509
Electron microscopy of biopsy material	EM	72851-72852
Electrophoresis, and immunofixation or immunoelectrophoresis or isoelectric focussing - characterisation of cryoglobulins	RYO	71059
Electrophoresis, and immunofixation or immunoelectrophoresis or isoelectric focussing - characterisation of paraprotein	PPRO	71059
Electrophoresis, to demonstrate - creatine kinase isoenzymes	CKIE	66518
Electrophoresis, to demonstrate - lactate dehydrogenase isoenzymes	LDI	66641
Electrophoresis, to demonstrate - lipoprotein subclasses	LEPG	66539
Electrophoresis - quantitation of paraprotein classes or paraprotein	EPPI	71057-71058
Elements (see individual elements)		
Endomysium antibodies	EMA	71160
Entamoeba histolytica - microbial antibody testing	AMO	69384
Enzyme assays of solid tissue or tissues	ENZS	66683
Enzyme histochemistry of skeletal muscle	EHSK	72844
Eosinophil cationic protein	ECP	71095
Epstein Barr virus - microbial antibody testing	EBV	69472 , 69474
Erythrocyte - assessment of haemolysis	ERYH	65075
Erythrocyte - assessment of metabolic enzymes	ERYM	65075
Erythrocyte - count	RCC	65070
Erythrocyte - sedimentation rate	ESR	65060
Ethosuximide (Zarontin)	ETHO	66611
Euglobulin clot lysis time	ECLT	65140
Extractable nuclear antigens - detection of antibodies to	ENA	71101
Eye - microscopy & culture of material from	MCSW	69303
Factor II	FII	65150
Factor IX	FIX	65150
Factor V	FV	65150
Factor V Leiden mutation	FVLM	65168 , 65174
Factor VII	FVII	65150
Factor VIII	VIII	65150
Factor X	FX	65150
Factor XI	FXI	65150
Factor XII	FXII	65150
Factor XIII	XIII	65150
Factor XIII deficiency test	F13D	65120
Faecal antigen test for Helicobacter pylori	FAHP	69366
Faecal blood	FOB	66764-66770
Faecal fat	FFAT	66674
Faecal fat - haemoglobin	FFH	66764
Faecal fat - reducing substances	FRS	66761
Faeces - culture	FCS	69345-69351
Faeces - microscopy for parasites	OCP	69336-69342

Ferritin (see also Iron studies)	FERR	66593
Fibrin monomer	FM	65120
Fibrinogen	FIB	65120
Fibrinogen - degradation products	FDP	65120
Fitzgerald factor	FGF	65150
Flecainide	FLEC	66611
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Fluorescent treponemal antibody - absorption test (FTA-ABS) - microbial antibody testing	FTA	69384
Fluoxetine	FLUX	66611
Foetal red blood cells - Kliehauer	KLEI	65162
Folate - red cell	RCF	66599
Follicle stimulating hormone (FSH)	FSH	66695
Frozen section diagnosis of biopsy material	FS	72855-72856
Fructosamine	FRUC	66557
Full blood examination	FBE	65070
Gamma glutamyl transpeptidase	GGT	66500
Gastric parietal cell - tissue antigens - antibodies	PCA	71119
Gastrin	GAST	66695
Gliadin IgA - tissue antigens - antibodies	GLIA	71119
Globulin	GLOB	66500
Glomerular basement membrane - tissue antigens - antibodies	GBA	71109
Glucagon	GLGO	66695
Glucagon stimulation test	GSTC	66689
Glucose	GLUC	66500
Glucose - tolerance test	GTT	66542
Glycosolated haemoglobin (Hb Alc)	GHB	66551
Gold	AU	66672-66673
Gonadotrophin	GRHS	66689
Group B streptococcus - CSF antigens	STB	69372
Group B streptococcus - microbial antigen testing	STB	69372
Group P9 - simple basic pathology tests		73801-73811
Growth hormone	GH	66695
Growth hormone - stimulation by exercise or L-dopa	GHSE	66686
Growth hormone - suppression by dexamethasone or glucose	GHSG	66686
Haematocrit	HCT	65070
Haemochromatosis	FEUP	66794
Haemoglobin	HB	65060
Haemoglobinopathy tests	HMGP	65081
Haemophilus influenzae - CSF antigens	HI	69372
Haemophilus influenzae - microbial antibody testing	HUS	69384
Haemophilus influenzae - microbial antigen testing	HI	69372
Haloperidol	HALO	66611
Haptoglobins	HGLB	66632
HDL cholesterol	HDLC	66536
Heart - tissue antigens - antibodies	AHE	71109
Heparin - test	HEPR	65144
Hepatitis B or C confirmatory test	HSVP	69484
Hepatitis B or C confirmatory test - including 1 marker	HSM1	69487
Hepatitis B or C confirmatory test - including 2 markers	HSM2	69490
Hepatitis B or C confirmatory test - including 3 markers	HSM3	69493
Hepatitis C - detection	RNAC	69444
Hepatitis C - genotype	GHCV	69443
Hepatitis C - quantitation	THCV	69442
Hepatitis investigation - 3 markers	HEP3	69481
Hepatitis serology - in pregnancy	HEPP	69405-69411
Hepatitis status or carriage - 1 marker	HEP1	69475
Hepatitis status or carriage - 2 markers	HEP2	69478
Herpes simplex virus - direct detection from clinical material	HSV	69375
Herpes simplex virus - investigation by culture	HSVC	69375

Herpes simplex virus - microbial antibody testing	HPA	69384
Herpes simplex virus - microbial antigen testing	HSV	69375
Heterophil antibodies	IM	65114
HIAA (hydroxyindoleacetic acid)	HIAA	66779
Histamine	HIAM	66779
Histone - tissue antigens - antibodies	AHI	71109
Histopathology of biopsy material	HIST	72813-72836
Histoplasma - microbial antibody testing	HIP	69384
HIV - antiretroviral therapy	TVLT	69381
HIV - cerebrospinal fluid	CVLT	69382
HIV - monitoring	MVLT	69378
HLA typing - HLA class 1	HLA1	71149
HLA typing - HLA class 2	HLA2	71151
HLA typing - HLA-B27	HLAB	71147
HMMA (hydroxy-3-methoxymandelic acid, previously known as VMA)	HMMA	66779
HMPG (hydroxy-methoxy phenylethylene glycol)	HMPG	66779
Homovanillic acid	HVA	66779
Hormones - stimulation by exercise or L-dopa	GHSE	66686
Hormone receptor assay - breast	HRA	66662
Hormone receptor assay - ovary	HRO	66662
Hormones - 11 deoxycortisol	DCOR	66695
Hormones - adrenocorticotrophic hormone	ACTH	66695
Hormones - aldosterone	ALDS	66695
Hormones - androstenedione	ANDR	66695
Hormones - calcitonin	CALT	66695
Hormones - cortisol	CORT	66695
Hormones - C-Peptide	CPEP	66695
Hormones - cyclic AMP	CAMP	66695
Hormones - dehydroepiandrosterone sulphate (DHEAS)	DHEA	66695
Hormones - dihydrotestosterone	DHTS	66695
Hormones - follicle stimulating hormone	FSH	66695
Hormones - gastrin	GAST	66695
Hormones - glucagon	GLGO	66695
Hormones - gonadotrophin	GRHS	66689
Hormones - growth hormone	GH	66695
Hormones - growth hormone - stimulation by exercise or L-dopa	GHSE	66686
Hormones - growth hormone - suppression by dexamethasone or glucose	GHSG	66686
Hormones - hormone receptor assay - breast	HRA	66662
Hormones - hormone receptor assay - ovary	HRO	66662
Hormones - human chorionic gonadotrophin - quantitation	HCG	66650-66653 , 66740 , 73529
Hormones - human chorionic gonadotrophin - detection for pregnancy diagnosis	HCGP	73527 , 73529
Hormones - human placental lactogen	HPL	66746
Hormones - hydroxyprogesterone	OHP	66695
Hormones - insulin	INS	66695
Hormones - insulin, hypoglycaemia test	INHY	66689
Hormones - luteinizing hormone	LH	66695
Hormones - oestradiol	E2	66695
Hormones - oestriol	E3	66740 , 66746
Hormones - oestrone	E1	66695
Hormones - parathyroid hormone	PTH	66695
Hormones - pentagastrin	PSTR	66689
Hormones - progesterone	PROG	66695
Hormones - prolactin	PROL	66695
Hormones - renin	REN	66695
Hormones - sex hormone binding globulin	SHBG	66695
Hormones - somatomedin	SOMA	66695
Hormones - suppression by dexamethasone or glucose	GHSG	66686
Hormones - testosterone	TES	66695
Hormones - urine steroid fraction or fractions	USF	66695

Hormones - vasoactive intestinal peptide	VIP	66695
Hormones - vasopressin	ADH	66695
Hormones & hormone binding proteins (see individual hormones and proteins)		66695
Huhner's test	HT	73521
Human chorionic gonadotrophin - quantitation	HCG	66650-66653 , 66740 , 73529
Human chorionic gonadotrophin - detection for pregnancy diagnosis	HCGP	73527 , 73529
Human placental lactogen	HPL	66746
HVA (homovanillic acid)	HVA	66779
Hydatid - microbial antibody testing	HYD	69384
Hydroxy methoxy phenylethylene glycol	HMPG	66779
Hydroxy-3-methoxy mandelic acid, previously known as VMA)	HMMA	66779
Hydroxychloroquine	HOCQ	66611
Hydroxyindoleacetic acid	HIAA	66779
Hydroxyprogesterone	OHP	66695
Hydroxyproline	HYDP	66752
Imipramine	IMIP	66611
Immediate frozen section diagnosis of biopsy material	FS	72855-72856
Immunocyto. 1-3 antibodies	ICC	73059
Immunocyto. 4+ antibodies	ICC1	73060
Immuno-electrophoresis and electrophoresis - characterisation of cryoglobulins	RYO	71059
Immuno-electrophoresis and electrophoresis - characterisation of paraprotein	PPRO	71059
Immunoglobulins - A	IGA	71066
Immunoglobulins - D	IGD	71074
Immunoglobulins - E (total)	IGE	71075-71079
Immunoglobulins - G	IGG	71068
Immunoglobulins - G, 4 subclasses	SIGG	71073
Immunoglobulins - M	IGM	71072
Immunohistochemical investigation of biopsy material	HIS	72846-72847
Infectious mononucleosis	IM	69384
Influenza A - microbial antibody testing	FLA	69384
Influenza B - microbial antibody testing	FLB	69384
Insulin	INS	66695
Insulin - hypoglycaemia test	INHYP	66689
Insulin - tissue antigens - antibodies	AINS	71109
Insulin receptor antibodies - tissue antigens - antibodies	INSA	71109
Intercellular cement substance of skin - tissue antigens - antibodies	ICCS	71109
Intestinal disaccharidases	INTD	66680
Intrinsic factor - tissue antigens - antibodies	AIF	71109
Iron studies (iron, transferrin & ferritin)	IS	66596
Islet cell - tissue antigens - antibodies	AIC	71109
Isoelectric focussing and electrophoresis - characterisation of cryoglobulins	RYO	71059
Isoelectric focussing and electrophoresis - characterisation of paraprotein	PPRO	71059
Jo-1 - tissue antigens - antibodies	JO1	71119
Keratin - tissue antigens - antibodies	KERA	71119
Kleihauer test	KLEI	65162
Lactate	LACT	66500
Lactate - dehydrogenase	LDH	66500
Lactate - dehydrogenase isoenzymes	LDI	66641
Lamellar body phospholipid	LBPH	66749
Lead	PB	66665
Lecithin/sphingomyelin ratio (amniotic fluid)	LS	66749
Legionella pneumophila - serogroup 1 - microbial antibody testing	LP1	69384
Legionella pneumophila - serogroup 2 - microbial antibody testing	LP2	69384
Leishmaniasis - microbial antibody testing	LEI	69384
Leptospira - microbial antibody testing	LEP	69384
Leucocyte count	WCC	65070
Leucocyte count - 3 surface markers - blood, CSF, serous fluid	LMH3	71139
Leucocyte count - 3 surface markers - tissue	LMT3	71141
Leucocyte count - 6 surface markers - blood, CSF, serous fluid & tissue(s)	LMHT	71145

Leucocyte count - 6 surface markers - blood, CSF, serous fluid or tissue	LM6	71143
Lignocaine	LIGN	66611
Lip - cytology on specimens from	SMCY	73043
Lipase	LIP	66500
Lipid studies (see test groups at para PQ.4)	FATS	66500
Lipoprotein subclasses - electrophoresis	LEPG	66539
Listeria - microbial antibody testing	LIS	69384
Lithium	LI	66611
Liver function tests (see test groups at para PQ.4)	LFT	66515
Liver/kidney microsomes - tissue antigens - antibodies	LKA	71119
Lupus anticoagulant	LUPA	65132-65137, 65142
Luteinizing hormone	LH	66695
Lymphocyte - tissue antigens - antibodies	ALY	71109
Lymphocytes - functional tests - 1 test	LF1	71127
Lymphocytes - functional tests - 2 tests	LF2	71129
Lymphocytes - functional tests - 3 tests	LF3	71131
Magnesium	MG	66500
Mammary serum antigen	MSA	66650
Manganese	MN	66669-66670
Mantoux test	MANT	73811
Measles - microbial antibody testing	MEA	69384
Mercury	HG	66672-66673
Metabolic bone disease	CBMB	66776
Methaemalbumin detection (Schumm's test)	SCHM	65117
Metanephrines	MNEP	66779
Methadone	MTDN	66611
Methotrexate	MTTA	66611
Methsuximide	MSUX	66611
Methylphenobarbitone	MPBT	66611
Metronidazole	MRDZ	66611
Mexiletine (Mexitil)	MEX	66611
Mianserin	MIAS	66611
Microalbumin	MALB	66560
Microbial antibody testing - actinomycetes	ACT	69384
Microbial antibody testing - adenovirus	ADE	69384
Microbial antibody testing - aspergillus	ASP	69384
Microbial antibody testing - avian precipitins (bird fancier's disease)	APP	69384
Microbial antibody testing - Blastomyces	BLM	69384
Microbial antibody testing - Bordetella pertussis	BOR	69384
Microbial antibody testing - Borrelia burgdorferi	BOB	69384
Microbial antibody testing - Brucella	BRU	69384
Microbial antibody testing - Campylobacter jejuni	CAM	69384
Microbial antibody testing - Candida	CAN	69384
Microbial antibody testing - Chlamydia	CHL	69384
Microbial antibody testing - Coccidioides	CCC	69384
Microbial antibody testing - Coxsackie B1-6	COX	69384
Microbial antibody testing - cryptococcus	CRY	69384
Microbial antibody testing - cytomegalovirus	CMV	69384
Microbial antibody testing - cytomegalovirus serology in pregnancy	CMVP	69384
Microbial antibody testing - dengue	DEN	69384
Microbial antibody testing - diphtheria	DIP	69384
Microbial antibody testing - echinococcus	ECC	69384
Microbial antibody testing - echo-coxsackie group	ECH	69384
Microbial antibody testing - Entamoeba histolytica	AMO	69384
Microbial antibody testing - Epstein Barr virus	EBV	69472, 69474
Microbial antibody testing - fluorescent treponemal antibody - absorption test (FTA-ABS)	FTA	69384
Microbial antibody testing - Haemophilus influenzae	HUS	69384
Microbial antibody testing - herpes simplex virus	HPA	69384
Microbial antibody testing - Histoplasma	HIP	69384

Microbial antibody testing - hydatid	HYD	69384
Microbial antibody testing - infectious mononucleosis	IM	69384
Microbial antibody testing - influenza A	FLA	69384
Microbial antibody testing - influenza B	FLB	69384
Microbial antibody testing - Legionella pneumophila - serogroup 1	LP1	69384
Microbial antibody testing - Legionella pneumophila - serogroup 2	LP2	69384
Microbial antibody testing - leishmaniasis	LEI	69384
Microbial antibody testing - Leptospira	LEP	69384
Microbial antibody testing - Listeria	LIS	69384
Microbial antibody testing - measles	MEA	69384
Microbial antibody testing - Micropolyspora faeni	MIC	69384
Microbial antibody testing - mumps	MUM	69384
Microbial antibody testing - Murray Valley encephalitis	MVE	69384
Microbial antibody testing - Mycoplasma pneumoniae	MYC	69384
Microbial antibody testing - Neisseria meningitidis	MEN	69384
Microbial antibody testing - Newcastle disease	NCD	69384
Microbial antibody testing - parainfluenza 1	PF1	69384
Microbial antibody testing - parainfluenza 2	PF2	69384
Microbial antibody testing - parainfluenza 3	PF3	69384
Microbial antibody testing - paratyphi	PTY	69384
Microbial antibody testing - pertussis	PER	69384
Microbial antibody testing - poliomyelitis	PLO	69384
Microbial antibody testing - Proteus OX 19	POX	69384
Microbial antibody testing - Proteus OXK	POK	69384
Microbial antibody testing - Q fever	QFF	69384
Microbial antibody testing - rapid plasma reagin test	RPR	69384
Microbial antibody testing - respiratory syncytial virus	RSV	69384
Microbial antibody testing - Ross River virus	RRV	69384
Microbial antibody testing - rubella	RUB	69384
Microbial antibody testing - Salmonella typhi (H)	SAH	69384
Microbial antibody testing - Salmonella typhi (O)	SAO	69384
Microbial antibody testing - Schistosoma	STO	69384
Microbial antibody testing - streptococcal serology - anti-DNASE B titre	ADNB	69384
Microbial antibody testing - streptococcal serology - anti-streptolysin O titre	ASOT	69384
Microbial antibody testing - Streptococcus pneumoniae	PCC	69384
Microbial antibody testing - tetanus	TET	69384
Microbial antibody testing - Thermoactinomyces vulgaris	THE	69384
Microbial antibody testing - thermopolyspora	TPS	69384
Microbial antibody testing - Toxocara	TOC	69384
Microbial antibody testing - toxoplasma	TOX	69384
Microbial antibody testing - TPHA (Treponema pallidum haemagglutination test)	TPHA	69384
Microbial antibody testing - Treponema pallidum haemagglutination test	TPHA	69384
Microbial antibody testing - trichinosis	TOS	69384
Microbial antibody testing - typhus, Weil-Felix	TYP	69384
Microbial antibody testing - Varicella zoster	VCZ	69384
Microbial antibody testing - VDRL (Venereal Disease Research Laboratory)	VDRL	69384
Microbial antibody testing - Yersinia enterocolitica	YER	69384
Microbial antigen testing - Chlamydia	MCCH	69315 , 69369
Microbial antigen testing - Clostridium difficile	CLDT	69363
Microbial antigen testing - group B streptococcus	STB	69372
Microbial antigen testing - Haemophilus influenzae	HI	69372
Microbial antigen testing - herpes simplex virus	HSV	69375
Microbial antigen testing - Neisseria gonorrhoeae	GON	69372
Microbial antigen testing - Neisseria meningitidis	NMG	69372
Microbial antigen testing - respiratory syncytial virus	RSVN	69372
Microbial antigen testing - Streptococcus pneumoniae	SPN	69372
Microbial antigen testing - Varicella zoster	VCZN	69375
Micropolyspora faeni	MIC	69384
Microscopic examination of - faeces for parasites	OCP	69336-69342
Microscopy of wet film material other than blood	MWFM	69300

Microscopy & culture of - material from nose, throat, eye or ear	MCSW	69303
Microscopy & culture of - material from skin	MCSK	69309
Microscopy and culture of - postoperative wounds, aspirates of body cavities	MCPO	69321
Microscopy & culture of - superficial sites	MCSS	69306
Microscopy & culture of - urethra, vagina, cervix or rectum	MCGR	69312
Microscopy & culture of - specimens of sputum	MCSP	69318
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 1 specimen	AFB1	69324
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 2 specimens	AFB2	69327
Microscopy & culture of - specimens of sputum, urine or other body fluids for mycobacteria 3 specimens	AFB3	69330
Microscopy & culture to detect pathogenic micro-organisms including chlamydia	MCCH	69315
Microscopy, culture, identification & sensitivity of urine	UMCS	69333
Mitochondria - tissue antigens - antibodies	MA	71119
Mouth - cytology on specimens from	SMCY	73043
Mumps - microbial antibody testing	MUM	69384
Murray Valley encephalitis - microbial antibody testing	MVE	69384
Mycobacteria microscopy & culture of sputum - 1 specimen	AFB1	69324
Mycobacteria microscopy & culture of sputum - 2 specimens	AFB2	69327
Mycobacteria microscopy & culture of sputum - 3 specimens	AFB3	69330
Mycoplasma pneumoniae - microbial antibody testing	MYC	69384
Myoglobin	MYOG	66518
N-acetyl procainamide	NAPC	66611
Neisseria gonorrhoeae by NAA techniques and chlamydia by any method	CHGO	69370
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Anus, neoplasm, biopsy	4
Anus, neoplasm, radical resection	6
Appendix	3
Artery, all specimens not otherwise specified	3
Artery, biopsy	4
Bartholin's gland - cyst	3
Bile duct, resection - all specimens	6
Bone, biopsy, curettings or fragments - lesion	5
Bone, biopsy or curettings quantitation - metabolic disease	6
Bone, femoral head	4
Bone, resection, neoplasm - all sites and types	6
Bone marrow, biopsy	4
Bone - all specimens not otherwise specified	4
Brain neoplasm, resection - cerebello-pontine angle	4
Brain or meninges, biopsy - all lesions	5
Brain or meninges, not neoplasm - temporal lobe	6
Brain or meninges, resection - neoplasm (intracranial)	5
Brain or meninges, resection - not neoplasm	4
Branchial cleft, cyst	4
Breast, excision biopsy, guidewire localisation - non-palpable lesion	6
Breast, excision biopsy, or radical resection, malignant neoplasm or atypical proliferative disease - all specimen types	6
Breast, incision biopsy or needle biopsy, malignant neoplasm - all specimen types	4
Breast - microdocheotomy	6
Breast tissue - all specimens not otherwise specified	4
Bronchus, biopsy	4
Carotid body - neoplasm	5
Cholesteatoma	3
Digits, amputation - not traumatic	4
Digits, amputation - traumatic	2
Ear, middle and inner - not cholesteatoma	4
Endocrine neoplasm - not otherwise specified	5
Extremity, amputation or disarticulation - neoplasm	6
Extremity, amputation - not otherwise specified	4
Eye, conjunctiva - biopsy or pterygium	3
Eye, cornea	4
Eye, enucleation or exenteration - all lesions	6
Eye - not otherwise specified	4
Fallopian tube, biopsy	4
Fallopian tube, ectopic pregnancy	4
Fallopian tube, sterilization	2
Fetus with dissection	6
Foreskin - new born	2
Foreskin - not new born	3
Gallbladder	3
Gallbladder and porta hepatis-radical resection	6
Ganglion cyst, all sites	3
Gum or oral mucosa, biopsy	4

Heart valve	4
Heart - not otherwise specified	5
Hernia sac	2
Hydrocele sac	2
Jaw, upper or lower, including bone, radical resection for neoplasm	6
Joint and periarticular tissue, without bone - all specimens	3
Joint tissue, including bone - all specimens	4
Kidney, biopsy including transplant	5
Kidney, nephrectomy transplant	5
Kidney, partial or total nephrectomy or nephroureterectomy - neoplasm	6
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Large bowel (including rectum), biopsy - all sites	4
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Large bowel, segmental resection - colon, not neoplasm	5
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Larynx, biopsy	4
Larynx, partial or total resection	5
Larynx, resection with nodes or pharynx or both	6
Lip, biopsy - all specimens not otherwise specified	3
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Liver, total or subtotal hepatectomy - neoplasm	6
Liver - all specimens not otherwise specified	5
Lung, needle or transbronchial biopsy	4
Lung, resection - neoplasm	6
Lung, wedge biopsy	5
Lung segment, lobar or total resection	6
Lymph node, biopsy - all sites	4
Lymph node, biopsy - for lymphoma or lymphoproliferative disorder	5
Lymph nodes, regional resection - all sites	5
Mediastinum mass	5
Muscle, biopsy	6
Nasopharynx or oropharynx, biopsy	4
Nerve, biopsy neuropathy	5
Nerve, neurectomy or removal of neoplasm	4
Nerve - not otherwise specified	3
Nose, mucosal biopsy	4
Nose or sinuses, polyps	3
Odontogenic neoplasm	5
Odontogenic or dental cyst	4
Oesophagus, biopsy	4
Oesophagus, diverticulum	3
Oesophagus, partial or total resection	6
Omentum, biopsy	4
Ovary with or without tube - neoplasm	5
Ovary with or without tube - not neoplasm	4
Pancreas, biopsy	5
Pancreas, cyst	4
Pancreas, subtotal or total with or without splenectomy	6
Parathyroid gland(s)	4
Penisectomy with node dissection	5
Penisectomy - simple	4
Peritoneum, biopsy	4
Pituitary neoplasm	4

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Placenta - third trimester, abnormal pregnancy or delivery	4
Pleura or pericardium, biopsy or tissue	4
Products of conception, spontaneous or missed abortion	4
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Salivary gland - all specimens not otherwise specified	4
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Sinus, paranasal, resection - neoplasm	6
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Skin, biopsy - inflammatory dermatosis	4
Skin, eyelid, wedge resection	4
Skin, local resection - orientation	4
Skin, resection of malignant melanoma with full evaluation including measurement of Breslow thickness and Clark level	5
Skin - all specimens not otherwise specified including all neoplasms and cysts	3
Small bowel - biopsy, all sites	4
Small bowel, diverticulum	3
Small bowel, resection - neoplasm	6
Small bowel - resection, all specimens	5
Soft tissue, infiltrative lesion, extensive resections at least 5cm in maximal dimension	6
Soft tissue, lipoma and variants	3
Soft tissue, neoplasm, not lipoma - all specimens	5
Soft tissue - not otherwise specified	4
Spleen	5
Stomach, endoscopic biopsy or endoscopic polypectomy	4
Stomach, resection, neoplasm - all specimens	6
Stomach - all specimens not otherwise specified	4
Tendon or tendon sheath, giant cell neoplasm	4
Tendon or tendon sheath - not otherwise specified	3
Testis, biopsy	5
Testis and adjacent structures, castration	2
Testis and adjacent structures, neoplasm with or without nodes	5
Testis and adjacent structures, vas deferens sterilization	2
Testis and adjacent structures - not otherwise specified	3
Thymus - not otherwise specified	5
Thyroglossal duct - all lesions	4
Thyroid - all specimens	5
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Tissue or organ not otherwise specified, haematoma	3
Tissue or organ not otherwise specified, malignant neoplasm with regional nodes	6
Tissue or organ not otherwise specified, neoplasm local	4
Tissue or organ not otherwise specified, pilonidal cyst or sinus	3
Tissue or organ not otherwise specified, thrombus or embolus	3
Tissue or organ not otherwise specified, veins varicosity	3
Tissue or organ - all specimens not otherwise specified	3
Tongue, biopsy	4
Tongue or tonsil, neoplasm local	5
Tongue or tonsil, neoplasm with nodes	6

Tonsil, biopsy - excluding resection of whole organ	4
Tonsil or adenoids or both	2
Trachea, biopsy	4
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Urinary bladder, partial or total with or without prostatectomy	6
Urinary bladder, transurethral resection of neoplasm	5
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Uterus, cervix cone, biopsy (including LLETZ or LEEP biopsy)	5
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Vagina, radical resection	6
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Vulva or labia, biopsy	4
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Commonwealth Department of Health and Ageing

**MEDICARE BENEFITS FOR
THE TREATMENT OF
CLEFT LIP AND CLEFT PALATE
CONDITIONS**

1 November 2002

At the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may be subject to the approval of Executive Council and Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for the payment of Medicare benefits.

INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for services rendered by eligible dental practitioners, orthodontists and oral surgeons for the treatment of cleft lip and cleft palate conditions. These arrangements operate under the Health Insurance Act 1973 (as amended).

Section 1 of this book contains explanatory notes on the Scheme together with an outline of the arrangements under which it operates, including addresses of the Health Insurance Commission and Cleft Lip and Cleft Palate Clinics.

The Schedule in Section 2 shows for each service the item number, description of the service, the Schedule fee and Medicare benefits. The fees shown in the Schedule are the fees which apply to services rendered on and after 1 November 2002.

This edition of the book has been printed for use by eligible dental practitioners, orthodontists, oral surgeons, the Health Insurance Commission and other interested authorities.

CHANGES INCLUDED IN THIS EDITION

General Fee Increase

Schedule fees for services by eligible dental practitioners in the treatment of cleft lip and cleft palate conditions increase by 2.5% from 1 November 2002.

Maximum Patient Gap

With effect from 1 November 2002, the maximum patient gap between the Medicare Benefits Schedule fee and the benefit payable for out-of-hospital medical services increases to \$57.10.

Special Arrangements - Transitional Period

Where an item refers to a service in which treatment continues over a period of time in excess of one day and treatment commenced before 1 November 2002 and continues beyond that date, the general rule is that the 1 November 2001 level of fees and benefits would apply.

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SECTION 1

OUTLINE OF ARRANGEMENTS AND NOTES FOR GUIDANCE OF DENTAL PRACTITIONERS

OUTLINE OF CLEFT LIP AND CLEFT PALATE SCHEME AND NOTES FOR GUIDANCE

CA. INTRODUCTION

CA.1 Medicare Benefits

CA.1.1 The Medicare Benefits Schedule includes certain professional services in respect of the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable. These services are normally described as dental services. However, for the purposes of these Notes the word "medical" is to be interpreted to include "dental". The definition of professional service as contained in the Health Insurance Act provides that such a service must be "clinically relevant". A clinically relevant service means a service rendered by a medical or dental practitioner or optometrist that is generally accepted in the medical, dental or optometrical profession (as the case may be) as being necessary for the appropriate treatment of the patient to whom it is rendered.

CA.1.2 Medicare benefits are payable in respect of services listed in the Schedule (contained in Section 2 of this booklet), when the services are rendered by eligible dental practitioners to prescribed patients (see paragraph [CC](#)).

CA.1.3 The Schedule lists three categories of professional services:

Group C1	Orthodontic Services
Group C2	Oral and Maxillofacial Surgical Services
Group C3	General and Prosthodontic Services

CB. DENTAL PRACTITIONER ELIGIBILITY

CB.1 Eligible Practitioners

CB.1.1 In order to attract Medicare benefits, all treatment must be carried out by eligible dental practitioners who are resident in Australia. Practitioner eligibility is covered under the provisions of Subsection 3(1) of the Health Insurance Act 1973 (the Act).

CB.1.2 All State registered dental practitioners are entitled to perform simple extraction services covered by Items 75200-75206 listed in Group [C2](#) of the Schedule (see paragraph [CG.6](#) of these notes) and the general and prosthodontic services listed in Group [C3](#) of the Schedule. Practitioners do not need to apply for accreditation or approval to perform these services.

CB.1.3 Dental practitioners who wish to be accredited for the purposes of Subsection 3(1) of the Act to perform those orthodontic services listed in Group [C1](#) of the Schedule must submit an application for consideration by the Medical Benefits (Dental Practitioners) Advisory Committee. This Committee will recommend to the Minister the names of those dental practitioners who, in its opinion, should be accredited by the Minister to provide orthodontic services.

CB.1.4 The criteria used in granting accreditation for orthodontic services are that the dental practitioner is a practitioner who is either -

- . registered by one of the State Dental Boards as an orthodontist; or
- . can substantiate by qualifications and experience a level of competence in the field of orthodontics equivalent to the above criterion.

CB.1.5 Oral and maxillofacial surgeons approved by the Minister for the purposes of Subsection 3 (1) of the Act to carry out prescribed medical services (oral and maxillofacial surgery) contained in the Medicare Benefits Schedule book are entitled (without the need to apply) to perform those items of oral and maxillofacial surgery listed in Group [C2](#) of this Schedule (on referral by an accredited orthodontist).

CB.1.6 The Medical Benefits (Dental Practitioners) Advisory Committee considers applications lodged by dental practitioners and recommends to the Minister the names of those dental practitioners who, in its opinion, should be approved by the Minister for the purposes of subsection 3(1) of the Act. Such dental practitioners must be State registered oral and maxillofacial surgeons in the State in which he/she is practising. In making its recommendations, the Committee may take into account a practitioner's training and experience in the field of oral and maxillofacial surgery and other factors which it may consider relevant.

CB.1.7 Practitioners who wish to be considered for approval or accreditation for the purposes of subsection 3(1) of the Act, should write to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT 2901 for an application form. Any enquiries may be directed to the Health Insurance Commission on (02) 6124 6753.

CB.1.8 Where the Minister decides that a dental practitioner should not be accredited for orthodontic services or approved for oral and maxillofacial surgical services, the dental practitioner may appeal to the Medical Benefits (Dental Practitioners) Appeals Committee, which is composed of dental practitioners who are not on the Advisory Committee. The Committee's address is the same as the Advisory Committee.

CB.1.9 Both the Advisory and the Appeals Committees are composed of dental practitioners nominated by the Australian Dental Association.

CC. PATIENT ELIGIBILITY

CC.1 Eligible Patients

CC.1.1 To be eligible to claim benefits for Schedule services performed by eligible dental practitioners, a patient must satisfy the following criteria:

- (a) The patient must be an Australian resident or any other person or class of persons whom the Minister declares to be eligible. All eligible persons will be issued with a Medicare card on application as evidence of their eligibility.
- (b) The patient must be aged less than twenty-two years.
- (c) Under the provisions of Subsection 3(1) of the Health Insurance Act a patient must be a prescribed dental patient, i.e. a person in respect of whom a certificate has been issued by a medical practitioner or dental practitioner approved by the Minister, stating that the person is suffering from a cleft lip or cleft palate condition*

* Conditions for which a patient may be prescribed include the following: .

- Branchial Arch Syndrome
- . Craniosynostosis Syndrome .
- Apert's Syndrome
- . Pierre Sequence
- . Treacher-Collins' Syndrome .
- Golden Har Syndrome
- . Ectodermal Dysplasia

CC.1.2 The identification of the cleft condition and the issue of the Certificate can be undertaken through a special cleft lip and palate clinic or by a medical or dental practitioner authorised for this purpose by the Minister. Cleft lip and palate clinics operate in at least one public hospital in each Australian State/Territory capital city. A list of these clinics and their addresses appears at the end of these Notes.

CC.1.3 Practitioners whose patients are unable to attend the hospital clinic should send records of the cleft condition to the Clinic for identification of the condition and issue of the Certificate.

CC.1.4 The Certificate is a formal document required under the provisions of the Act. Because the Certificate may have to last for up to twenty-two years, each eligible patient will also be issued with a plastic identification card. These cards, which are more durable than the paper Certificates, can be used by patients (or parents or guardians) to claim Medicare benefits. Facsimiles of the Certificate and card appear at the end of these Notes.

CC.1.5 Patients are eligible for Medicare benefits for treatment received from the date of issue of their Certificate. Where treatment is required immediately after birth, practitioners should telephone a Clinic or approved practitioner so that a Certificate can be prepared which will be effective from that day.

CC.2 Visitors to Australia

CC.2.1 Medicare benefits are generally not payable to visitors to Australia or temporary residents. People visiting Australia specifically for medical or hospital treatment are not eligible for Medicare benefits.

CC.3 Health Care Expenses Incurred Overseas

CC.3.1 Medicare does not cover medical or hospital expenses incurred outside Australia.

CD. SCHEDULE FEES AND MEDICARE BENEFITS

CD.1 Schedule Fees and Medicare Benefits

CD.1.1 Medicare benefits are based on fees determined for each Schedule service. These fees are shown in the Schedule in Section 2 of this Book. The fee is referred to in these notes as the "Schedule fee". The fee for any item listed in the Schedule is that which is regarded as being reasonable on average for that service having regard to usual and reasonable variations in the time involved in performing the service on different occasions and to reasonable ranges of complexity and technical difficulty encountered.

CD.1.2 The Medicare benefits for each medical service are the amounts shown immediately after the Schedule fee. There are presently two levels of Medicare benefit payable, that is:-

- (i) for professional services rendered while hospital treatment (i.e., accommodation and nursing care) is provided to a patient who has been admitted to a hospital or day hospital facility (other than public patients), the level of Medicare benefit is 75% of the Schedule fee for each item with no maximum patient gap between the Medicare benefit and the Schedule fee. The Health Insurance Regulations provide that medical practitioners must indicate on their accounts, etc, where a medical service is rendered in these circumstances. This requirement will be met by placing the word "admitted patient" immediately preceding the description of each service or, alternatively, where an item number is used, by placing an asterisk "*" directly after the item number for each service.
- (ii) for all other professional services, the Medicare benefit is 85% of the Schedule fee, or the Schedule fee less \$57.10 (indexed annually) whichever is the greater.

Where appropriate the calculated benefit has been rounded to the nearest higher 5 cents. However, in no circumstances will the benefit payable for any service exceed the amount of the fee actually charged for that service.

CD.1.3 It should be noted that the Health Insurance Act makes provision for private medical insurance to cover the "patient gap" (ie., the difference between the Medicare benefit and the Schedule fee) for services attracting benefit at the 75% level. Patients may insure with private health insurance organisations for the gap between the 75% Medicare benefit and the Schedule fee or for amounts in excess of the Schedule fee where the patient has an agreement with their health fund.

CD.1.4 Where it can be established that payments for out-of-hospital services of \$309.80 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the Assignment of Benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

CD.2 Where Medicare Benefits are not Payable

CD.2.1 Medicare benefits are not payable in respect of a professional service in the following circumstances:-

- (i) where the medical expenses for the service are paid or payable to a recognised (public) hospital;
- (ii) where the service is a medical examination for the purposes of - life insurance, superannuation or provident account scheme, or admission to membership of a friendly society;
- (iii) where the service was rendered in the course of carrying out of mass immunisation.

CD.2.2 Unless the Minister otherwise directs, Medicare benefit is not payable in respect of a professional service where:-

- (a) the service has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory;
- (b) the medical expenses were incurred by the employer of the person to whom the service was rendered;
- (c) the person to whom that service was rendered was employed in an industrial undertaking and that service was rendered to him for purposes connected with the operation of that undertaking; or
- (d) the service was a health screening service.

CD.2.3 The legislation empowers the Minister to make regulations to preclude the payment of Medicare benefits for professional services rendered in prescribed circumstances. Such regulations, however, may only be made in accordance with a recommendation made by the Medicare Benefits Advisory Committee.

CD.2.4 Benefits are not payable for items [75150](#) to [75621](#) unless the patient was referred in the manner outlined at paragraph CG.6.

CD.3 Workers' Compensation, Third Party Insurance, Damages etc.

CD.3.1 From 1 February 1996, Medicare benefits are payable for medical expenses for professional services that are wholly covered by workers' compensation or damages under a Commonwealth or State or Territory law, except where a person has entered into a "reimbursement arrangement" with a compensation insurer. The normal billing arrangements apply in respect of services rendered.

CD.3.2 Once a settlement or judgement is made on a compensation claim, recovery of benefits is undertaken between the insurer or compensation payer, the compensable person and the Health Insurance Commission. The recovery arrangements do not impact on practitioners.

CD.4 Limiting Rule

CD.4.1 In no circumstances will the benefit payable for a professional service exceed the fee charged for the service.

CE. PENALTIES

CE.1 Penalties

CE.1.1 Penalties of up to \$10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences by a Court on or after 22 February 1986 shall be subject to an examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.

CE.1.2A penalty of up to \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct billing form without the necessary details having been entered on the form before signature or who fails to cause a copy of the completed form to be given to the patient.

CF. BILLING PROCEDURES

CF.1 Billing of the Patient - Itemised Accounts

CF.1.1 Where the practitioner bills the patient for medical services rendered, the patient needs a properly itemised account/receipt to enable a claim to be made for Medicare benefits.

CF.1.2 Under the provisions of the Health Insurance Act and Regulations, Medicare benefits are not payable in respect of a professional service unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of the service, the following particulars:-

- (i) Patient's name;
- (ii) The date on which the professional service was rendered;
- (iii) A description of the professional service sufficient to identify the item that relates to that service, including an indication where the service is rendered to a person while hospital treatment is provided in a hospital or day-hospital facility (other than a Medicare hospital patient), that is, the words (i.e., accommodation and nursing care) "admitted patient" immediately preceding the description of the service or an asterisk "*" directly after an item number where used;
- (iv) The name and practice address or name and provider number of the practitioner who actually rendered the service; (Where the practitioner has more than one practice location recorded with the Health Insurance Commission, the provider number used should be that which is applicable to the practice location at or from which the service was given).

CF.1.3 Each account must also carry a certification by the accredited dental practitioner that:- (i) the patient's eligibility certificate or identification card has been sighted (this can be done by quoting the number on the identification card); and

- (ii) the service was required for the treatment associated with the cleft condition.

CF.1.4 Where a practitioner wishes to apportion the total fee between the appropriate professional fee for the particular service and any balance outstanding in respect of services rendered previously, the practitioner should ensure that the balance is described in such a way (e.g. balance of account) that it cannot be mistaken as being a separate service. In particular no item number should be shown against the balance.

CF.1.5 Only one original itemised account should be issued in respect of any one medical service and any duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

CF.2 Claiming Benefits

CF.2.1 The patient, upon receipt of a practitioner's account, has two courses open for paying the account and receiving benefits as outlined below.

CF.3 Paid Accounts

CF.3.1 The patient may pay the account and subsequently present the receipt at a Medicare customer service centre for assessment and payment of the Medicare benefit in cash.

CF.3.2 In these circumstances, where a claimant personally attends a customer service centre, the claimant is not required to complete a Medicare Patient Claim Form (PC1).

CF.3.3 In circumstances where the claimant is seeking a cheque payment of the Medicare benefit or is arranging for an agent to receive the Medicare benefit on the claimant's behalf, completion of a Medicare Patient Claim Form (PC1) is still required.

CF.4 Unpaid Accounts

CF.4.1 Where the patient has not paid the account, the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the practitioner.

CF.4.2 It will be the patient's responsibility to forward the cheque to the practitioner and make arrangements for payment of the balance of the account if any. "Pay doctor" cheques involving Medicare benefits cannot be sent direct to practitioners or to patients at a practitioner's address (even if requested by the patient to do so). "Pay doctor" cheques will be forwarded to the claimant's last known address.

CF.4.3 When issuing a receipt to a patient in respect of an account that is being paid wholly or in part by a Medicare "pay doctor" cheque the practitioner should indicate on the receipt that a "Medicare" cheque for \$.....was involved in the payment of the account.

CF.5 Assignment of Benefits (Direct-Billing) Arrangements

CF.5.1 Under the Health Insurance Act the Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need. If a practitioner direct-bills, the practitioner undertakes to accept the relevant Medicare benefit as full payment for the service. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:-

- . The patient's Medicare card number must be quoted on all direct-bill forms for that patient.
- . The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
- . The forms include information required by Regulations under Subsection 19(6) of the Health Insurance Act.
- . The practitioner must cause the particulars relating to the professional service to be set out on the assignment form before the patient signs the form and cause the patient to receive a copy of the form as soon as practicable after the patient signs it.

Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the practitioner, practitioner's staff, hospital proprietor, hospital staff, residential aged care facility proprietor or residential aged care facility staff) is acceptable. The reason the patient is unable to sign should also be stated. In the absence of a "responsible person" the patient signature section should be left blank and in the section headed "Practitioner's Use" or on the back of the assignment form, an explanation should be given as to why the patient was unable to sign (e.g. unconscious, injured hand, etc.) and this note should be signed or initialled by the doctor. If in the opinion of the practitioner the reason is of such a "sensitive" nature that revealing it would constitute an unacceptable breach of patient confidentiality or unduly embarrass or distress the recipient of the patient's copy of the assignment of benefits form, a concessional reason "due to medical condition" to signify that such a situation exists may be substituted for the actual reason. However, this should not be used routinely and in most cases it is expected that the reason given will be more specific.

CF.5.2 The administration of the direct-billing arrangements under Medicare as well as the payment of Medicare benefits on patient claims is the responsibility of the Health Insurance Commission. Any enquires in regard to these matters should therefore be directed to the Commission's Medicare offices or enquiry points.

CF.5.3 Under Medicare any eligible dental practitioner can accept assignment of benefit and direct-bill for any eligible person.

CF.6 Use of Medicare Cards in Direct Billing

CF.6.1 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be issued on an individual or family basis. Up to 5 persons may be listed on the one Medicare card, and up to 9 persons may be listed under the one Medicare card number.

CF.6.2 The Medicare card plays an important part in direct billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter has been developed for this purpose and is available free of charge, on request, from Medicare.

CF.6.3 The patient details can of course be entered on the direct-bill forms by hand, but the use of a card to imprint patient details assists practitioners and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.

CF.6.4 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient is not eligible and Medicare benefits not payable.

CF.6.5 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the practitioner may contact a Medicare telephone enquiry number to obtain the number.

CF.7 Assignment of Benefit Forms

CF.7.1 To meet varying requirements the following types of stationery are available from Medicare. Note that these forms are approved forms under the Health Insurance Act, and no other forms can be used to assign benefits without the approval of the Health Insurance Commission.

- (a) *Form DB2*. This form is used to assign benefits for services other than requested pathology. It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a Patient copy and a Practitioner copy.
- (b) *Form DB4*. Is a continuous stationery version of Form DB2, and has been designed for use on most office accounting machines.

CF.8 The Claim for Assigned Benefits (Form DB1, DB1H)

CF.8.1 Practitioners who accept assigned benefits must claim on Medicare using Form DB1 or DB1H, the Claim for Assigned Benefits. The DB1H form should be used where services are rendered to persons while hospital treatment is provided in a hospital or day hospital facility (other than Medicare hospital patients). Both forms have been designed to enable benefit for a claim to be directed to a practitioner other than the one who rendered the services. The facility is intended for use in situations such as where a short term locum is acting on behalf of the principal practitioner and setting the locum up with a provider number and pay-group link for the principal practitioner's practice is impractical. Practitioners should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.

CF.8.2 The claim form must be accompanied by the Assignment forms to which the claim relates.

CF.8.3 Forms DB1 and DB1H are also loose leaf similar to form DB2 to enable imprinting of practitioner details using the special Medicare imprinter. For this purpose, practitioner cards showing the practitioner's name, practice address and provider number are available from Medicare on request.

CF.9 Direct-Bill Stationery

CF.9.1 Medical practitioners and eligible dental practitioners wishing to direct-bill may obtain direct-bill stationery by contacting any Medicare Office. Information on the completion of the forms and direct-bill procedures are provided with the forms. Information on direct-billing is available from any Medicare office.

CF.10 Time Limits Applicable to Lodgement of Claims for Assigned Benefits

CF.10.1 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (assignment of benefit) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.

CF.10.2 Provision exists whereby in certain circumstances (e.g. hardship cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

CG. COMPILATION AND INTERPRETATION OF THE SCHEDULE

CG.1 Compilation of the Schedule

CG.1.1 Section 2 of this Book lists the item number, description of medical service, the Schedule fee for those services in the treatment of cleft lip and cleft palate conditions for which Medicare benefits are payable and the Medicare benefits.

CG.1.2 The prescribed services have been grouped according to the general nature of the services: orthodontic, oral surgical and general and prosthodontic.

CG.2 Principles of Interpretation

CG.2.1 Each professional service listed in the Schedule is a complete medical service in itself. Where a service is rendered partly by one practitioner and partly by another, only the one amount of benefit is payable.

CG.3 Multiple Operation Rule

CG.3.1 The Schedule fee for two or more operations performed on a patient on the one occasion are calculated by the following rule:-

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

NOTE:1. Fees so calculated which result in a sum which is not a multiple of 5 cents are taken to the next higher multiple of 5 cents.

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

3. The Schedule fee for benefits purposes is the aggregate of the fees calculated in accordance with the above formula.

CG.3.2 The above rule does not apply to an operation which is one of two or more operations performed under the one anaesthetic on the same patient by different dental practitioners unless either practitioner assists the other. In this case, the fees and benefits specified in the Schedule apply. For these purposes the term "operation" includes items [75200- 75615](#).

CG.3.3 If the operation comprises a combination of procedures which are commonly performed together and for which a specific combined item is provided in the Schedule, it is regarded as the one item and service in applying the multiple operation rule.

CG.4 Administration of Anaesthetics by Medical Practitioners

CG.4.1 When a medical practitioner administers an anaesthetic in connection with a dental procedure prescribed for the payment of Medicare benefits (and the procedure has been performed by an eligible dental practitioner), Medicare benefits are payable for the administration of the anaesthetic on the same basis as if the procedure had been rendered by a medical practitioner.

CG.4.2 To ascertain the Schedule fee for the anaesthetic, medical practitioners should refer to Group T6, Subgroup 3 of the Medicare Benefits Schedule Book.

CG.5 Definitions

CG.5.1 Orthodontic treatment planning is defined as the measurement and analysis of the face and jaws and occlusion providing a diagnosis and planned prescription of appliances and treatment required.

CG.5.2 Study models are defined as orthodontic plaster casts of the upper and lower teeth and alveolar processes.

CG.6 Oral and Maxillofacial Surgical Services - Referral ([75150 - 75621](#))

CG.6.1 Benefits are payable for items 75150 to 75621 only where the service has been rendered to a patient who has been referred by letter of Referral by a dental practitioner accredited for orthodontic services.

CG.7 General and Prosthodontic Services (75800)

CG.7.1 Item number [75800](#) refers to a consultation by a dentist for prevention and prophylaxis and includes such services as dietary advice, oral hygiene and fluoride treatment.

CG.8 Over-servicing

CG.8.1 Over-servicing must be avoided. In the case of denture services, examples of over-servicing might be:-

- Unjustifiably frequent replacement of dentures;
- Provision of new dentures when relining or re-modelling of an existing prosthesis would meet the clinical need;

- Provision of metal dentures where an acrylic denture would meet the clinical need.

CG.8.2 The Schedule includes an item for metal dentures to allow for the provision of a precise, long-term prosthesis. The item is not intended for use during the period of growth, where prostheses must be replaced or altered frequently, unless there is some definite and extraordinary clinical requirement.

HEALTH INSURANCE COMMISSION

(Postal : Medicare, GPO Box 9822, in each Capital City, Phone Enquiries on 132 150)

NEW SOUTH WALES

State Headquarters Colonial
Tower
150 George Street
PARRAMATTA NSW 2150 Tel (02) 9895 3333

VICTORIA

Medibank House
460 Bourke Street
MELBOURNE 3000 Tel (03) 9605 7333

QUEENSLAND

State Headquarters
444 Queen Street
BRISBANE 4000 Tel (07) 3004 5333

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD 5063 Tel (08) 8274 9333

WESTERN AUSTRALIA

State Headquarters
11th Floor
Bank West Tower
108 St. George's Terrace
PERTH 6000 Tel (08) 9214 8333

TASMANIA

State Headquarters
242 Liverpool Street
HOBART 7000 Tel (03) 6215 5333

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG 2901 Tel (02) 6124 6333

NORTHERN TERRITORY

As per South Australia

CLEFT LIP AND CLEFT PALATE CLINICS

NEW SOUTH WALES

Dental Department
Westmead Children's Hospital
Locked Bag 4001
Cnr Hawkesbury Rd & Hainsworth Street
WESTMEAD 2145 (02) 9845 2582

Orthodontic Department
United Dental Hospital of Sydney
2nd Floor
2 Chalmers Street
SURRY HILLS 2010 (02) 9293 8314

Children's Outpatients
Sydney Children's Hospital
High Street
RANDWICK 2031 (02) 9382 1470

Paediatric Outpatient's Dept.
John Hunter Children's Hospital
Locked Bag 1
NEWCASTLE MC 2310 (02) 4921 3750

VICTORIA

Cleft Palate Clinic
Monash Medical Centre
246 Clayton Road
CLAYTON 3168 (03) 9594 2380

Cleft Coordinator
Department of Plastic and Maxillofacial Surgery
Royal Children's Hospital
Flemington Road
PARKVILLE 3052 (03) 9345 6582

QUEENSLAND

Children's Oral Health Service Level
5, Coles Health Services Centre Royal
Children's Hospital
Herston Road
HERSTON 4029 (07) 3636 1025

Combined Cleft Lip & Palate Clinic
Townsville Cleft Palate Clinic
Special Clinics
Townsville General Hospital
Eyre Street
NORTH WARD QLD 4810 (07) 4781 9304

Children's Specialist Clinic
Mater Children's Hospital
Annerley Road
SOUTH BRISBANE QLD 4101 (07) 3840 8180

SOUTH AUSTRALIA

Director
Paediatric Dental Unit
Women and Children's Hospital
72 King William Road
NORTH ADELAIDE 5006 (08) 8161 7379

Dental Clinic
Flinders Medical Centre
South Road
BEDFORD PARK 5042 (08) 8204 4188

WESTERN AUSTRALIA

Dental Unit
Princess Margaret Hospital
Thomas Street
SUBIACO 6008 (08) 9340 8342

TASMANIA

Oral and Maxillofacial Unit Level
5A
Royal Hobart Hospital Liverpool
Street
HOBART 7000 (03) 6222 8413

AUSTRALIAN CAPITAL TERRITORY

School Dental Clinic
ACT Health
1st Floor
Cnr Alinga and Moore Streets CANBERRA
CITY 2600 (02) 6205 5111
(Enquiries only)

NORTHERN TERRITORY

Senior Dentist Urban
Northern Territory Department of Health
Dental Clinic
48 Mitchell Street
DARWIN NT 0800 (08) 8924 4440

Northern Territory Department of Health
Dental Clinic
Community Health Centre
Flynn Drive
ALICE SPRINGS 0870 (08) 8951 6713

SECTION 2

SCHEDULE OF SERVICES

ORTHODONTIC	ORTHODONTIC
GROUP C1 - ORTHODONTIC SERVICES	
<p><i>Note: In this Group, benefit is only payable where the service has been rendered to a patient by a dental practitioner who has been accredited by the Minister to provide orthodontic services, except for the services covered by Items 75009-75023 which may also be rendered by a dental practitioner approved by the Minister to provide oral surgical services.</i></p>	
CONSULTATIONS	
75001	INITIAL PROFESSIONAL ATTENDANCE in a single course of treatment by an accredited orthodontist Fee: \$69.35 Benefit: 75% = \$52.05 85% = \$58.95
75004	PROFESSIONAL ATTENDANCE by an accredited orthodontist subsequent to the first professional attendance by the orthodontist in a single course of treatment Fee: \$34.80 Benefit: 75% = \$26.10 85% = \$29.60
75006	PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item 75004 applies) prior to provision of a service to which: (a) item 75030 , 75033 , 75034 , 75036 , 75037 , 75039 , 75045 or 75051 applies; (b) an item in Group T8 or Groups 03 to 09 applies; in a single course of treatment Fee: \$61.80 Benefit: 75% = \$46.35 85% = \$52.55
RADIOGRAPHY	
75009	ORTHODONTIC RADIOGRAPHY orthopantomography (panoramic radiography), including any consultation on the same occasion Fee: \$55.25 Benefit: 75% = \$41.45 85% = \$47.00
75012	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings OR LATERAL CEPHALOMETRIC RADIOGRAPHY with cephalometric tracings including any consultation on the same occasion Fee: \$87.55 Benefit: 75% = \$65.70 85% = \$74.45
75015	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings including any consultation on the same occasion Fee: \$120.45 Benefit: 75% = \$90.35 85% = \$102.40
75018	ORTHODONTIC RADIOGRAPHY ANTEROPOSTERIOR AND LATERAL CEPHALOMETRIC RADIOGRAPHY, with cephalometric tracings and orthopantomography including any consultation on the same occasion Fee: \$153.40 Benefit: 75% = \$115.05 85% = \$130.40
75021	ORTHODONTIC RADIOGRAPHY hand-wrist studies (including growth prediction) including any consultation on the same occasion Fee: \$188.15 Benefit: 75% = \$141.15 85% = \$159.95
75023	INTRAORAL RADIOGRAPHY - single area, periapical or bitewing film Fee: \$37.65 Benefit: 75% = \$28.25 85% = \$32.05
PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING	
75024	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision - WHERE 1 APPLIANCE IS USED Fee: \$486.60 Benefit: 75% = \$364.95 85% = \$429.50
75027	PRESURGICAL INFANT MAXILLARY ARCH REPOSITIONING including supply of appliances and all adjustments of appliances and supervision WHERE 2 APPLIANCES ARE USED Fee: \$667.15 Benefit: 75% = \$500.40 85% = \$610.05
DENTITION TREATMENT	
75030	MAXILLARY ARCH EXPANSION not being a service associated with a service to which item 75039 , 75042 , 75045 or 75048 applies, including supply of appliances, all adjustments of the appliances, removal of the appliances and retention Fee: \$594.10 Benefit: 75% = \$445.60 85% = \$537.00

ORTHODONTIC		ORTHODONTIC	
75033	MIXED DENTITION TREATMENT - incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of the appliances and retention Fee: \$973.65 Benefit: 75% = \$730.25 85% = \$916.55		
75034	MIXED DENTITION TREATMENT - incisor alignment with or without lateral arch expansion using a removable appliance in the maxillary arch, including supply of appliances, associated adjustments and retention Fee: \$495.60 Benefit: 75% = \$371.70 85% = \$438.50		
75036	MIXED DENTITION TREATMENT - lateral arch expansion and incisor alignment using fixed appliances in maxillary arch, including supply of appliances, all adjustments of appliances, removal of appliances and retention Fee: \$1,344.90 Benefit: 75% = \$1,008.70 85% = \$1,287.80		
75037	MIXED DENTITION TREATMENT - lateral arch expansion and incisor correction - 2 arch (maxillary and mandibular) using fixed appliances in both maxillary and mandibular arches, including supply of appliances, all adjustments of appliances, removal of appliances and retention Fee: \$1,693.85 Benefit: 75% = \$1,270.40 85% = \$1,636.75		
75039	PERMANENT DENTITION TREATMENT SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment Fee: \$450.15 Benefit: 75% = \$337.65 85% = \$393.05		
75042	PERMANENT DENTITION TREATMENT - SINGLE ARCH (mandibular or maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each 3 months of active treatment (including all adjustments and maintenance and removal of the appliances) after the first for a maximum of a further 33 months Fee: \$168.35 Benefit: 75% = \$126.30 85% = \$143.10		
75045	PERMANENT DENTITION TREATMENT 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - initial 3 months of active treatment Fee: \$901.20 Benefit: 75% = \$675.90 85% = \$844.10		
75048	PERMANENT DENTITION TREATMENT - 2 ARCH (mandibular and maxillary) TREATMENT (correction and alignment) using fixed appliances, including supply of appliances - each subsequent 3 months of active treatment (including all adjustments and maintenance, and removal of the appliances) after the first for a maximum of a further 33 months Fee: \$231.10 Benefit: 75% = \$173.35 85% = \$196.45		
75049	RETENTION, FIXED OR REMOVABLE, single arch (mandibular or maxillary) - supply of retainer and supervision of retention Fee: \$270.50 Benefit: 75% = \$202.90 85% = \$229.95		
75050	RETENTION, FIXED OR REMOVABLE, 2-arch (mandibular and maxillary) - supply of retainers and supervision of retention Fee: \$522.15 Benefit: 75% = \$391.65 85% = \$465.05		
	JAW GROWTH GUIDANCE		
75051	JAW GROWTH guidance using removable or functional appliances, including supply of appliances and all adjustments to appliances Fee: \$801.60 Benefit: 75% = \$601.20 85% = \$744.50		

GROUP C2 - ORAL AND MAXILLOFACIAL SERVICES

*Note: (i) In this Group, benefit is only payable where the service has been rendered to a patient who has been referred by an accredited orthodontist.
(ii) While benefit is payable for simple extractions performed by a registered dental practitioner, benefit is only payable for surgical extractions and other surgical procedures where the service is rendered by a dental practitioner who has been approved by the Minister to provide oral surgical services. (see para [CB1.5](#))*

CONSULTATIONS

INITIAL PROFESSIONAL attendance in a single course of treatment by an accredited oral and maxillofacial surgeon where the patient is referred to the surgeon by an accredited orthodontist
(See para [CG](#), of explanatory notes to this Category)

75150 **Fee:** \$69.35 **Benefit:** 75% = \$52.05 85% = \$58.95

PROFESSIONAL ATTENDANCE by an accredited oral and maxillofacial surgeon subsequent to the first professional attendance by the surgeon in a single course of treatment where the patient is referred to the surgeon by an accredited orthodontist
(See para [CG](#), of explanatory notes to this Category)

75153 **Fee:** \$34.80 **Benefit:** 75% = \$26.10 85% = \$29.60

PRODUCTION OF DENTAL STUDY MODELS (not being a service associated with a service to which item [75153](#) applies) prior to provision of a service:
(a) to which item 52321, 53212 or [75618](#) applies; or
(b) to which an item in the series 52330 to 52382, 52600 to 52630, 53400 to 53409 or 53415 to 53429 applies; in a single course of treatment
(See para [CG](#), of explanatory notes to this Category)

75156 **Fee:** \$61.80 **Benefit:** 75% = \$46.35 85% = \$52.55

SIMPLE EXTRACTIONS

REMOVAL OF TOOTH OR TOOTH FRAGMENT not being treatment to which item [75400](#), [75403](#), [75406](#), [75409](#), [75412](#) or [75415](#) applies
(See para [CG](#), of explanatory notes to this Category)

75200 **Fee:** \$44.55 **Benefit:** 75% = \$33.45 85% = \$37.90

REMOVAL OF TOOTH OR TOOTH FRAGMENT under general anaesthesia
(See para [CG](#), of explanatory notes to this Category)

75203 **Fee:** \$66.85 **Benefit:** 75% = \$50.15 85% = \$56.85

REMOVAL OF EACH ADDITIONAL TOOTH OR TOOTH FRAGMENT at the same attendance at which a service to which item [75200](#) or [75203](#) applies is rendered
(See para [CG](#), of explanatory notes to this Category)

75206 **Fee:** \$22.15 **Benefit:** 75% = \$16.65 85% = \$18.85

SURGICAL EXTRACTIONS

SURGICAL REMOVAL OF ERUPTED TOOTH (See para [CG](#), of explanatory notes to this Category) **Fee:**

75400 \$133.60 **Benefit:** 75% = \$100.20 85% = \$113.60

SURGICAL REMOVAL OF TOOTH with soft tissue impaction
(See para [CG](#), of explanatory notes to this Category)

75403 **Fee:** \$153.40 **Benefit:** 75% = \$115.05 85% = \$130.40

SURGICAL REMOVAL OF TOOTH with partial bone impaction
(See para [CG](#), of explanatory notes to this Category)

75406 **Fee:** \$174.90 **Benefit:** 75% = \$131.20 85% = \$148.70

SURGICAL REMOVAL OF TOOTH with complete bone impaction
(See para [CG](#), of explanatory notes to this Category)

75409 **Fee:** \$198.05 **Benefit:** 75% = \$148.55 85% = \$168.35

SURGICAL REMOVAL OF TOOTH FRAGMENT involving soft tissue only
(See para [CG](#), of explanatory notes to this Category)

75412 **Fee:** \$110.60 **Benefit:** 75% = \$82.95 85% = \$94.05

ORAL AND MAXILLOFACIAL **ORAL AND MAXILLOFACIAL**

75415	SURGICAL REMOVAL OF TOOTH FRAGMENT involving bone <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$133.60	Benefit: 75% = \$100.20	85% = \$113.60
OTHER SURGICAL PROCEDURES				
75600	SURGICAL EXPOSURE, STIMULATION AND PACKING OF UNERUPTED TOOTH <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$188.15	Benefit: 75% = \$141.15	85% = \$159.95
75603	SURGICAL EXPOSURE OF UNERUPTED TOOTH for the purpose of fitting a traction device <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$221.10	Benefit: 75% = \$165.85	85% = \$187.95
75606	SURGICAL REPOSITIONING OF UNERUPTED TOOTH <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$221.10	Benefit: 75% = \$165.85	85% = \$187.95
75609	TRANSPLANTATION OF TOOTH BUD <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$330.10	Benefit: 75% = \$247.60	85% = \$280.60
75612	SURGICAL PROCEDURE for intra oral implantation of osseointegrated fixture (first stage) <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$408.55	Benefit: 75% = \$306.45	85% = \$351.45
75615	SURGICAL PROCEDURE FOR FIXATION of trans-mucosal abutment (second stage of osseointegrated implant) <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$151.20	Benefit: 75% = \$113.40	85% = \$128.55
75618	PROVISION AND FITTING OF A BITE RISING APPLIANCE or DENTAL SPLINT for the management of temporomandibular joint dysfunction syndrome <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$187.80	Benefit: 75% = \$140.85	85% = \$159.65
75621	THE PROVISION AND FITTING OF SURGICAL TEMPLATE in conjunction with orthognathic surgical procedures in association with: (a) an item in the series 52342 to 52375; or (b) item 52380 or 52382 <i>(See para CG. of explanatory notes to this Category)</i>	Fee: \$187.80	Benefit: 75% = \$140.85	85% = \$159.65

GENERAL AND PROSTHODONTIC		GENERAL AND PROSTHODONTIC	
GROUP C3 - GENERAL AND PROSTHODONTIC SERVICES			
<i>Note: Benefit is payable for services listed in this Group where they are rendered by a State registered dental practitioner</i>			
CONSULTATIONS			
75800	ATTENDANCE BY AN ELIGIBLE DENTAL PRACTITIONER involving consultation, preventive treatment and prophylaxis, of not less than 30 minutes' duration each attendance to a maximum of 3 attendances in any period of 12 months Fee: \$66.85	Benefit: 75% = \$50.15	85% = \$56.85
PROSTHODONTIC			
75803	PROVISION AND FITTING OF ACRYLIC BASE PARTIAL DENTURE, including retainers 1 TOOTH Fee: \$267.35	Benefit: 75% = \$200.55	85% = \$227.25
75806	2 TEETH Fee: \$313.55	Benefit: 75% = \$235.20	85% = \$266.55
75809	3 TEETH Fee: \$371.30	Benefit: 75% = \$278.50	85% = \$315.65
75812	4 TEETH Fee: \$412.55	Benefit: 75% = \$309.45	85% = \$355.45
75815	5 TO 9 TEETH Fee: \$503.35	Benefit: 75% = \$377.55	85% = \$446.25
75818	10 TO 12 TEETH Fee: \$594.10	Benefit: 75% = \$445.60	85% = \$537.00
75821	PROVISION AND FITTING OF CAST METAL BASE (cobalt chromium alloy) PARTIAL DENTURE including casting and retainers 1 TOOTH Fee: \$478.50	Benefit: 75% = \$358.90	85% = \$421.40
75824	2 TEETH Fee: \$552.85	Benefit: 75% = \$414.65	85% = \$495.75
75827	3 TEETH Fee: \$635.35	Benefit: 75% = \$476.55	85% = \$578.25
75830	4 TEETH Fee: \$701.40	Benefit: 75% = \$526.05	85% = \$644.30
75833	5 TO 9 TEETH Fee: \$858.10	Benefit: 75% = \$643.60	85% = \$801.00
75836	10 TO 12 TEETH Fee: \$981.85	Benefit: 75% = \$736.40	85% = \$924.75
75839	PROVISION AND FITTING OF RETAINERS not being a service associated with a service to which item 75803 , 75806 , 75809 , 75812 , 75815 , 75818 , 75821 , 75824 , 75827 , 75830 , 75833 or 75836 applies each retainer Fee: \$22.15	Benefit: 75% = \$16.65	85% = \$18.85
75842	ADJUSTMENT OF PARTIAL DENTURE not being a service associated with a service to which item 75803 , 75806 , 75809 , 75812 , 75815 , 75818 , 75821 , 75824 , 75827 , 75830 , 75833 or 75836 applies Fee: \$33.00	Benefit: 75% = \$24.75	85% = \$28.05
75845	RELINING OF PARTIAL DENTURE by laboratory process and associated fitting Fee: \$165.10	Benefit: 75% = \$123.85	85% = \$140.35
75848	REMODELLING AND FITTING OF PARTIAL DENTURE of more than 4 teeth Fee: \$198.05	Benefit: 75% = \$148.55	85% = \$168.35
75851	REPAIR TO CAST METAL BASE OF PARTIAL DENTURE 1 or more points Fee: \$99.00	Benefit: 75% = \$74.25	85% = \$84.15

GENERAL AND PROSTHODONTIC**GENERAL AND PROSTHODONTIC**

75854	ADDITION OF A TOOTH OR TEETH to a partial denture to replace extracted tooth or teeth including taking of necessary impression Fee: \$99.00 Benefit: 75% = \$74.25 85% = \$84.15
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Commonwealth Department of Health and Ageing

**MEDICARE BENEFITS FOR
CONSULTATIONS BY OPTOMETRISTS**

Effective 1 November 2002

At the time of printing, the relevant legislation giving authority for changes included in this edition of the book may still be subject to the approval of Executive Council and Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

INTRODUCTION

This book provides information on the arrangements for the payment of Medicare benefits for optometric consultations by optometrists who undertake to participate in the benefits arrangements and by optometrists acting on their behalf. These arrangements operate under the Health Insurance Act 1973 (as amended).

Section 1 of this book contains an outline of the arrangements for optometric consultation benefits and notes for the guidance of participating optometrists, including addresses of the Department and the Health Insurance Commission.

The Schedule in Section 2 shows the item number, description of service, Schedule fee and Medicare benefit payable in respect of the optometric items.

Section 3 contains a copy of the Common Form of Undertaking which optometrists are required to sign to participate in the arrangements.

This edition of the book has been printed for use by participating optometrists, the Health Insurance Commission and other interested authorities.

CHANGES INCLUDED IN THIS EDITION

General Fee Increase

Schedule fees for optometric consultation items have increased by 2.5% from 1 November 2002.

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SECTION 1

OUTLINE OF ARRANGEMENTS AND NOTES FOR GUIDANCE

OUTLINE OF PROVISIONS FOR MEDICARE BENEFITS FOR OPTOMETRIC CONSULTATIONS AND NOTES FOR GUIDANCE

O1. INTRODUCTION

- O1.1 All Australian residents and certain categories of visitors to Australia can claim Medicare benefits for consultations with participating optometrists. The Health Insurance Act contains legislation covering the major elements of the Medicare program.
- O1.2 Responsibility for regulating the Medicare program lies with the Commonwealth Government through the Department of Health and Aged Care. The Health Insurance Commission (HIC) is responsible for consideration of applications for the acceptance of optometric undertakings and for the day to day operation of Medicare and the payment of benefits. Addresses of the Department and the HIC (Medicare offices) are located at the end of these Notes.

O2. PARTICIPATION BY OPTOMETRISTS

- O2.1 Medicare pays benefits for consultations with optometrists who have signed an agreement to participate in arrangements with the Commonwealth Government. This agreement is formally known as the "Common Form of Undertaking - Participating Optometrists" and is often referred to as the Participating Agreement. A copy of the Undertaking is contained in Section 3 of this book.
- O2.2 An optometrist registered or licensed under a law in any State or Territory of Australia, who wishes to become a participating optometrist, is required to sign the Common Form of Undertaking and an employer of optometrists must sign a separate common form of undertaking except where the optometrist and the owner of the business are the same person.
- O2.3 Where the optometric practice is conducted in a corporate form, such as a company or partnership, it is necessary for the corporation to become a "participating optometrist", and an additional undertaking must be signed by a person who has authority to give the undertaking on behalf of the organisation.
- O2.4 The undertaking sets out the obligations to be met under the arrangements. Copies of the undertaking may be obtained from the Provider Liaison Section, Health Insurance Commission at the addresses listed at the end of these Notes.
- O2.5 Where an employer of optometrists completes an undertaking, that undertaking must identify premises owned by them or in their possession. The relevant details are to be included in schedules 2 and 3 of the undertaking. An undertaking completed by an individual optometrist does not need to identify the premises from which services are to be provided as the Common Form of Undertaking applies to all premises from which the optometrists will provide services.
- O2.6 When completed, the undertaking should be returned to the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong, ACT 2901.
- O2.7 The Minister may refuse to accept an undertaking given by an optometrist. In these circumstances the optometrist will be notified in writing of the refusal and is given 30 days to forward a written request to the Minister, to have the matter referred to the Professional Services Review Tribunal.
- O2.8 After acceptance by the Minister, or his delegate, of the completed undertaking, a letter of acceptance of the undertaking will be forwarded to the optometrist. At the same time, the HIC will send the optometrist a supply of assignment forms and claim forms for assignment of Medicare benefits, together with the necessary instructions for direct-billing purposes.
- O2.9 The Manager (Eligibility) must be notified in writing of any changes to the details furnished by an optometrist in schedule 2 and schedule 3 of the undertaking.
- O2.10 Participating optometrists may at any time terminate undertakings either wholly or as they relate to particular premises, by notifying the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901. The date of termination may not be earlier than 30 days after the date on which the notice is served.
- O2.11 The names and addresses of participating optometrists may be obtained from the Manager (Eligibility), Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901, if the Minister or the Minister's delegate certifies in writing that this is necessary in the public interest.

O3. PROVIDER NUMBERS

- O3.1 To ensure that benefits are paid only for services provided by optometrists registered in a State or Territory of Australia, each optometrist providing consultations for which a Medicare benefit is payable requires an individual provider number.
- O3.2 Provider numbers will be issued only to individual participating optometrists registered in a State or Territory of Australia. Corporations, other business entities and individuals who are not registered optometrists will not be issued with provider numbers.
- O3.3 Provider numbers are allocated to practitioners to enable claims for Medicare benefits to be processed and cheques to be correctly drawn in favour of the practitioner where applicable. The number may be up to eight characters. The second last character identifies the practice location, the last being a check character.

- O3.4 Optometrists can obtain a provider number from Medicare. A separate provider number is issued for each location at which an optometrist practices and has current State/Territory registration. Provider numbers for additional practice locations may also be obtained from Medicare following confirmation of State/Territory registration. Optometrists cannot use another optometrist's provider number.
- O3.5 If a practitioner wishes Medicare benefits cheques, which would normally be drawn in favour of the practitioner, to be made payable to another payee and/or another address, written authority can be given to Medicare to do this. This payment to another party is known as a pay group link. There can only be one pay group link for an individual practice location but multiple practitioners and practice locations can be linked to one pay group. Further information on pay group links may be obtained from Medicare (addresses at the end of the Notes).

Locum Tenens

- O3.6 An optometrist who has signed a Common Form of Undertaking and is to provide services at a practice location as a locum for more than 2 weeks or will return to the practice on a regular basis for short periods should apply for a provider number for that location.
- O3.7 If the locum is to provide services at a practice for less than 2 weeks, the locum can use their own provider number or can obtain an additional provider number for that location (see O3.4).
- O3.8 Normally, Medicare benefits are payable for services rendered by an optometrist only when the optometrist has completed a Common Form of Undertaking. However, benefits may be claimed for services provided by an optometrist who has not signed the Undertaking if the optometrist has provided them on behalf of an optometrist who has signed the Common Form of Undertaking. To ensure benefits are payable when a locum practices in these circumstances, the locum optometrist should:
- Check that they will be providing optometry services on behalf of a participating optometrist ie their employer has a current "Common Form of Undertaking"
 - Notify the HIC in writing, before commencing the locum arrangement of the name and address of the participating optometrist on whose behalf they will be providing services.
- O3.9 Locums can direct Medicare payments to a third party eg the principal of the practice, by either arranging a pay group link and/or by nominating the principal as the payee provider on direct bill stationery (see para O3.5, [7.22](#)).

O4. PATIENT ELIGIBILITY

Eligible persons

- O4.1 For the purpose of the optometric arrangements, an eligible person is:
- a person who holds the normal Medicare card as issued to Australian residents; or
 - a person who holds a Medicare card which shows "Visitor" and the period of eligibility.
- O4.2 Medicare benefits are not payable for optometric consultations for persons holding a Medicare card which is endorsed "Reciprocal Health Care" on the face of the card.
- O4.3 See paragraph O4.5 below for details on the various types of Medicare cards issued.

Medicare cards

- O4.4 An eligible person who applies to enrol for Medicare benefits (using a Medicare Enrolment/ Amendment Application) will be issued with a uniquely numbered Medicare card which shows the Medicare Card number, the patient identification number (reference number), the applicant's first given name, initial of second given name, surname and an effective "valid to" date. These cards may be individual or family based. Up to five persons may be listed on the one Medicare card, and up to nine persons may be listed under the one Medicare card number.
- O4.5 Currently, there are three types of Medicare cards issued:
- the normal card for Australian residents which has only the month and year to which the card is valid at the bottom right hand side of the card and entitles the bearer to unrestricted access to Medicare benefits.
 - a visitor card which entitles the bearer to unrestricted access to Medicare benefits. Persons who would be issued with this type of card are persons who have come to Australia under various longer term Government schemes which have special Government approval. The Medicare card shows "VISITOR" and an expiry date at the bottom of the card.
 - a Reciprocal Health Care Agreement card for persons from countries which have an Agreement with Australia to provide access to Medicare for services that are "immediately necessary" medical and hospital treatment but NOT optometric consultations. The Medicare card differs in colour to the usual Medicare card, is endorsed "RECIPROCAL HEALTH CARE" and includes a "valid to" date.

Note: A Reciprocal Health Care Agreement card is NOT valid for optometric consultations.

Optometric expenses overseas

- O4.6 Medicare benefits under the Health Insurance Act are not available in respect of services rendered outside Australia. It is recommended that Australian residents travelling overseas take out private travellers or health insurance, which offers adequate coverage for the countries to be visited.

O5. BENEFITS FOR SERVICES BY PARTICIPATING OPTOMETRISTS

What services are covered

- O5.1 The services coming within the scope of the optometric consultation benefit arrangements are those clinically relevant services ordinarily rendered by the optometrist in relation to consultation on ocular or vision problems.
- O5.2 Benefits may only be claimed when:
- (a) a procedure has been performed and a clinical record of the consultation has been made;
 - (b) a significant consultation or examination procedure has been carried out;
 - (c) the consultation has been performed at premises listed in an undertaking;
 - (d) the consultation has involved the personal attendance of both the patient and the optometrist; and
 - (e) the service is "clinically relevant", (as defined in the Health Insurance Act,) ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered.

Where Medicare benefits are not payable

- O5.3 Medicare benefits may not be claimed for attendances for:
- (a) delivery, dispensing, adjustment or repairs of visual aids;
 - (b) filling of prescriptions written by other practitioners
- O5.4 Benefits are not payable for optometrical services associated with:
- (i) cosmetic surgery
 - (ii) refractive surgery
 - (iii) tests for fitness to undertake sporting, leisure or vocational activities
 - (iv) compulsory examinations or tests to obtain any commercial licence (eg flying or driving)
 - (v) entrance to schools or other educational facilities
 - (vi) compulsory examinations for admissions to aged care facilities
 - (vii) vision screening
- O5.5 Medicare benefits are not payable for services in the following circumstances:
- (a) where the expenses for the service are paid or payable to a recognised (public) hospital;
 - (b) where the service is provided by teaching institutions to patients of supervised students;
 - (c) where the service is not "clinically relevant" (as described in the Health Insurance Act, ie a service rendered by an optometrist that is generally accepted in the optometric profession as being necessary for the appropriate treatment of the patient to whom it is rendered).
- O5.6 Unless the Minister otherwise directs, a benefit is not payable in respect of an optometric consultation where:
- (a) the consultation has been rendered by or on behalf of, or under an arrangement with, the Commonwealth, a State or a local governing body or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory; or
 - (b) the consultation was rendered in one or more of the following circumstances -
 - (i) the employer arranges or requests the consultation
 - (ii) the results are provided to the employer by the optometrist
 - (iii) the employer requires that the employee have their eyes examined
 - (iv) the account for the consultation is sent to the employer
 - (v) the consultation takes place at the patient's workplace or in a mobile consulting room at the patient's workplace.

Services rendered to an optometrist's dependants, employer or practice partner or dependants

- O5.7 A condition of the participating arrangement is that the optometrist agrees not to submit an account or a claim for services rendered to any dependants of the optometrist, to his or her employer or practice partner or any dependants of that employer or partner.

Workers' compensation, third party insurance, damages, etc.

- O5.8 From 1 February 1996, Medicare benefits are payable for optometric expenses for professional services that are wholly covered by workers compensation or damages under a Commonwealth or State or Territory law.
- O5.9 The only exception to this is where a person has entered into a reimbursement arrangement with a compensation insurer. In such cases, a Medicare benefit is not payable. (A reimbursement arrangement is an agreement between a compensation claimant and the insurer stating that the optometric expenses of the person will be paid by the insurer as and when they arise.)
- O5.10 The practitioner has the option to either bulk-bill Medicare or give the patient a private account as would normally occur with any other consultation.
- O5.11 There are arrangements in place to recover any Medicare benefits paid as a result of the injury once a settlement or judgement is made on the compensation claim. The recovery is done between the insurer or compensation payer, the compensable person and Medicare. These recovery arrangements do not impact on practitioners.

O6. SCHEDULE FEES AND MEDICARE BENEFITS

Schedule fees and Medicare benefits

- O6.1 Optometrists participating in the scheme agree not to charge more than the Schedule fees for services covered by Medicare, and also, that charges for appliances shall not include any amount related to consultation procedures for which benefits are payable. The only exceptions are for Item 10907 and in relation to domiciliary visits - see paragraphs O6.13 and [O6.18](#).
- O6.2 The services provided by participating optometrists which attract benefits are set out in the Health Insurance Regulations. Details of the services, including the Schedule fee and Medicare benefits for each service are contained in Section 2 of this book.
- O6.3 Medicare benefits are payable at 85% of the Schedule fee for services rendered with a maximum gap payment for any one service of \$57.10 (indexed annually) between the Medicare rebate and the Schedule fee.
- O6.4 Where it can be established that payments of \$309.80 (indexed annually from 1 January) have been made for a family group or an individual during a calendar year in respect of the difference between the Medicare benefit and the Schedule fee for services rendered, benefits will be paid for expenses incurred for professional services rendered during the rest of that year up to 100% of the Schedule fee. This does not apply to the assignment of benefit arrangements. A family group includes a spouse and dependent children under 16 years of age or dependent students under the age of 25.

Limiting rule for patient claims

- O6.5 Where a fee charged for a consultation is less than the Medicare benefit, the benefit will be reduced to the amount of the fee actually charged. In no case will the benefit payable exceed the fee charged.

Multiple attendances

- O6.6 Payment of benefit may be made for several attendances on a patient on the same day by the same optometrist provided that the subsequent attendances are not a continuation of the initial or earlier attendances. However, there should be a reasonable lapse of time between the consultations before they can be regarded as separate attendances.
- O6.7 Where two or more attendances are made on the one day by the same optometrist the time of each attendance should be stated on the account (eg 10.30 am and 3.15 pm) in order to assist in the payment of benefits.
- O6.8 In some circumstances a subsequent consultation on the same day may be judged to be a continuation of an earlier attendance and a second benefit is not payable. For example, a preliminary eye examination may be concluded with the instillation of mydriatic or cycloplegic drops and some time later additional examination procedures are undertaken. These sessions are regarded as being one attendance for benefit purposes.

Referred comprehensive initial consultations (Item [10905](#))- Read in conjunction with [09.1](#) - [09.13](#)

- O6.9 For the purposes of Item [10905](#), the referring optometrist, having considered the patient's need for the referred consultation, is required to provide a written referral, dated and signed, and setting out the patient's condition and the reason for the referral.
- O6.10 Benefits will be paid at the level of Item [10905](#) providing the referral is received before the provision of the service, and providing the account, receipt or bulk-billing form contains the name and provider number of the referring optometrist.
- Referrals from medical practitioners do not attract benefit under item [10905](#).
- O6.11 The optometrist claiming the Item [10905](#) service is obliged to retain the written referral for a period of twenty-four months.
- O6.12 Referrals must be at "arms length". That is to say, no commercial arrangements or connections should exist between the optometrists.

Second comprehensive initial consultation within 24 months of a previous comprehensive consultation (Item [10907](#))

- O6.13 Where a patient receives a comprehensive initial consultation within 24 months of a previous comprehensive consultation provided by another optometrist an additional fee may be charged provided that the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the difference between the Schedule fees for Item [10900](#) and Item [10907](#).
- O6.14 In circumstances where an additional fee is charged the optometrist must inform the patient of the benefit payable for Item [10907](#) at the time of the consultation and that the additional fee will not attract benefits.
- O6.15 Where it is necessary for the optometrist to seek patient information from Medicare in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims, the optometrist must ensure that:-
(a) the patient is advised of the need to seek the information and the reason the information is required;
(b) the patient's informed consent to the release of information has been obtained; and
(c) the patient's records verify the patient's consent to the release of information.

Significant change in visual function requiring comprehensive re-evaluation (Item [10912](#))

- O6.16 Significant changes in visual function which justify the charging of Item [10912](#) include documented changes of:-
- vision or visual acuity of 2 lines (0.2 logMAR) or more (corrected or uncorrected)
- visual fields or previously undetected field loss

- binocular vision
- contrast sensitivity or previously undetected contrast sensitivity loss

New Signs or symptoms/progressive disorder requiring comprehensive re-evaluation (Items [10913](#) and [10914](#))

O6.17 When charging Item [10913](#) or Item [10914](#), the optometrist must document the new signs or symptoms or the nature of the progressive disorder suffered by the patient on the patient's record card. Progressive disorders may include conditions such as maculopathy (including age related maculopathy or diabetic retinopathy) cataract, corneal dystrophies, glaucoma etc.

Domiciliary visits

- O6.18 A domiciliary visit is one conducted away from the optometrist's practice at the patient's place of residence, be it their home, nursing home or hospital.
- O6.19 In the case of a domiciliary visit provided at the patient's request an extra fee may be charged, in addition to the Schedule fee provided the service is not direct-billed. The actual additional amount charged is a matter between the optometrist and the patient but it must not exceed an amount equal to the fee for Item [10900](#) - Initial Consultation.
- O6.20 No Medicare benefits are payable for the additional amount that may be charged for a domiciliary visit. The patient must make up the difference between the rebate and the fee charged.
- O6.21 Charges for domiciliary visits should be shown separately on accounts issued by optometrists and not included in the fee for the consultation (refer paragraph [O7.11](#)).

Release of prescription

- O6.22 Where a spectacle prescription is prepared for the patient, it becomes the property of the patient, who is free to have the spectacles dispensed by a person of the patient's choice. The optometrist will ensure that the patient is made aware that he or she is entitled to a copy of the spectacle prescription.
- O6.23 Contact lens prescriptions are excluded from the above provision, although the prescription remains the property of the patient and should be available to the patient at the completion of the prescription and fitting process.

Reminder notices

O6.24 The optometrist will ensure that any notice sent to a patient suggesting re-examination is sent solely on the basis of the clinical needs of the patient.

Aftercare period following surgery

- O6.25 Medicare schedule items that apply to surgery include all professional attendances necessary for the post-operative treatment of the patient. The aftercare period includes all post-operative treatment, whether provided by a medical practitioner or an optometrist. The amount and duration of the aftercare may vary but includes all attendances until recovery from the operation. Attendances provided by an optometrist in the aftercare period do not attract a Medicare benefit.
- O6.26 The rebate for cataract surgery includes payment for aftercare attendances so payment for aftercare services provided by an optometrist on behalf of a surgeon should be arranged with the surgeon. The optometrist should not charge the patient. In the case of cataract surgery, the first visit following surgery for which the optometrist can charge a rebatable fee is generally the attendance at which a prescription for spectacles or contact lenses is written.
- O6.27 Medicare benefits are not available for refractive surgery, consultations in preparation for the surgery or consultations in the aftercare period. Charges for attendances by optometrists may be made directly to the patient or to the surgeon depending on the arrangements made prior to surgery. Accounts and receipt issued to the patient should clearly indicate the fee is non-rebatable.

O7. BILLING PROCEDURES

- O7.1 There are three ways benefits may be paid for optometric consultations:
- (i) the patient may pay the optometrist's account and then claim benefits from a Medicare office by submitting the account and the receipt;
 - (ii) the patient may submit the unpaid account to Medicare which will then draw a cheque in favour of the optometrist; or
 - (iii) the optometrist may bill Medicare instead of the patient for the consultation. This mechanism is known as direct billing. If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient.

Note: **Additional charges must not be levied in respect of domiciliary visits and consultations covered by Item [10907](#) if the services are direct-billed.**

Claiming of benefits

O7.2 The patient, upon receipt of an optometrist's account, has two courses open for paying the account and receiving benefits.

Paid accounts

- O7.3 If the account has been paid, the claimant can obtain a cash benefit (up to certain limits) from a Medicare office. Alternatively they may lodge a claim by post, by fax in selected pharmacies and Rural Transaction Centres, or telephone (in rural areas throughout Australia) for a payment by Electronic Funds Transfer (EFT) or cheque.

Unpaid accounts

- O7.4 Where the patient has not paid the account the unpaid account may be presented to Medicare with a Medicare claim form. In this case Medicare will forward to the claimant a benefit cheque made payable to the optometrist.
- O7.5 It is the patient's responsibility to forward the cheque to the optometrist and make arrangements for payment of the balance of the account, if any. "Pay optometrist cheques" involving Medicare benefits cannot be sent direct to optometrists, or to patients at an optometrist's address (even if requested by the patient to do so). "Pay optometrist cheques" will be forwarded to the patient's normal address.
- O7.6 When issuing a receipt to a patient for an account that is being paid wholly or in part by a Medicare "pay optometrist cheque" the optometrist should indicate on the receipt that a "Medicare" cheque for \$..... was involved in the payment of the account.

Itemised accounts

- O7.7 When an optometrist bills a patient for a consultation, the patient should be issued with a properly itemised account and receipt to enable him/her to claim Medicare benefits.
- O7.8 Medicare benefits are not payable in respect of an optometric consultation unless there is recorded on the account setting out the fee for the service or on the receipt for the fee in respect of each consultation to each patient, the following information:-
- (i) patient's name;
 - (ii) date on which the consultation was rendered;
 - (iii) a description of the consultation (eg "initial consultation, "subsequent consultation" or "contact lens consultation");
 - (iv) Medicare Benefits Schedule item number;
 - (v) the name and practice address or name and provider number of the optometrist who actually rendered the service. Where the optometrist has more than one practice location, the provider number used should be that which is applicable to the practice location where the service was given;
 - (vi) the fee charged for that consultation;
 - (vii) the time each consultation began if the optometrist attended the patient on more than one occasion on the same day and on each occasion rendered a professional service relating to an optometric item;
- O7.9 The optometrist billing for the service bears responsibility for the accuracy and completeness of the information included on accounts, receipts and assignment of benefits forms even where such information has been recorded by an employee of the optometrist.
- O7.10 Payment of benefits could be delayed or disallowed if the account does not clearly identify the service as one which qualifies for Medicare benefits or that the practitioner is a registered optometrist practising at the address where the service was rendered. It is important to ensure that an appropriate description of the service, the item number and the optometrist's provider number is included on accounts, receipts and assignment forms.
- O7.11 Details of any charges made other than for consultations, eg a dispensing charge, a charge for a domiciliary visit, should be shown separately either on the same account or on a separate account.
- O7.12 Patients must be eligible to receive Medicare benefits and must also meet the clinical requirements outlined in the relevant item descriptors.

Duplicate accounts

- O7.13 Only one original itemised account per consultation should be issued. Duplicates of accounts or receipts should be clearly marked "duplicate" and should be issued only where the original has been lost. Duplicates should not be issued as a routine system for "accounts rendered".

Assignment of benefit (direct billing) arrangements

- O7.14 Under the Health Insurance Act an Assignment of Benefit (direct-billing) facility for professional services is available to all persons in Australia who are eligible for benefit under the Medicare program. This facility is NOT confined to pensioners or people in special need.
- O7.15 If an optometrist direct-bills, he/she undertakes to accept the relevant Medicare benefit as full payment for the consultation. Additional charges for that service (irrespective of the purpose or title of the charge) cannot be raised against the patient. Under these arrangements:
- The patient's Medicare number must be quoted on all direct-bill forms for that patient.
 - The basic forms provided are loose leaf to enable the patient details to be imprinted from the Medicare card.
 - The optometrist must state the particulars relating to the consultation on the assignment form before the patient signs the form and give the patient a copy of the form as soon as practicable after the patient signs it.

- Where a patient is unable to sign the assignment form the signature of the patient's parent, guardian or other responsible person (other than the participating optometrist, participating optometrist's staff, hospital proprietor, hospital staff, nursing home proprietor or nursing home staff) is acceptable. The reason the patient was unable to sign should be stated.
- In the absence of a "responsible person" the patient signature section on the form should be left blank and an explanation as to why the patient was unable to sign should be given in the section headed "Practitioner Use" or on the back of the assignment form. The Attending Optometrist should initial the explanation. If the reason for the patient being unable to sign would be an unacceptable breach of confidentiality or would be unduly embarrassing or distressing, the optometrist may explain the situation using the concessional reason "due to medical condition". This wording should not be used routinely and in most cases it is expected that the reason given would be more specific.

Use of Medicare cards in direct billing

- O7.16 The Medicare card plays an important part in direct-billing as it can be used to imprint the patient details (including Medicare number) on the basic direct-billing forms. A special Medicare imprinter is used for this purpose and is available free of charge, on request, from Medicare.
- O7.17 The patient details can, of course, be entered on the direct-bill forms by hand, but the use of the card to imprint patient details assists optometrists and ensures accuracy of information. The latter is essential to ensure that the processing of a claim by Medicare is expedited.
- O7.18 The Medicare card number must be quoted on direct-bill forms. If the number is not available, then the assignment of benefit facility should not be used. To do so would incur a risk that the patient may not be eligible and Medicare benefits not payable.
- O7.19 Where a patient presents without a Medicare card and indicates that he/she has been issued with a card but does not know the details, the optometrist may contact a Medicare telephone enquiry number to obtain the number.
- O7.20 It is important for the optometrist to check the eligibility of patients for Medicare benefits by reference to the card, as entitlement is limited to the "valid to" date shown on the bottom of the card. Additionally the card will show if a person is enrolled through a Reciprocal Health Care Agreement. Benefits are not payable for this category.

Assignment of benefit forms

- O7.21 Only the approved forms available from the HIC can be used to direct bill patients for optometric consultations and no other form can be used without the approval of the Commission.
- (a) *Form DB2*
It is loose leaf for imprinting and comprises a throw away cover sheet (after imprinting), a Medicare copy, a patient copy and a practitioner copy.
- (b) *Form DB4*
This is a continuous stationery version of Form DB2 and has been designed for use on most office accounting machines.

The claim for assigned benefits (Form DB1)

- O7.22 Optometrists who accept assigned benefits ie, who direct bill on behalf of a patient, must claim from Medicare using Claim for Assigned Benefits form DB1. The form has been designed to enable the payment to be made to an optometrist other than the one who rendered the service. This facility is intended for use in situations such as where a short-term locum is acting on behalf of the principal optometrist and setting the locum up with a provider number and pay-group link is impractical. It should be noted that in order to use this facility, the provider number of the principal optometrist should be indicated in the section "Payee's Provider Number". Optometrists should note that this facility cannot be used to generate payments to or through a person who does not have a provider number.
- O7.23 Each claim form must be accompanied by the assignment forms to which the claim relates.
- O7.24 The DB1 is also loose leaf to enable imprinting of optometrists' details using the special Medicare imprinter. For this purpose, optometrist cards, showing the optometrist's name, practice address and provider number are available from the HIC on request.
- O7.25 When an optometrist direct-bills Medicare, the assignment forms take the place of the conventional accounts and receipts. It is important therefore, that the assignment forms show for each service to each patient the information required on patient's accounts as mentioned in paragraph [O7.8](#).
- O7.26 Detailed instructions regarding requirements for completion and submission of claims for assigned benefits are included with the assignment stationery provided by the HIC.
- O7.27 The assignment form should be signed by the patient. The name of the optometrist who conducted the examination should be shown in the space on the form titled "Name of practitioner who actually rendered the professional service being claimed" together with his/her provider number or address.
- O7.28 The claim form must be signed and dated by the optometrist who rendered the services described on the assignment forms attached to the claim form. This claim form must also be witnessed and the witness identified.
- O7.29 A claim form together with corresponding assignment forms should be forwarded to the HIC at the convenience of the optometrist. The only proviso is that there should be no more than fifty (50) assignment forms with each claim. If more than 50 are received processing may be delayed.

Time limits applicable to lodgement of claims for Medicare benefits

- O7.30 A time limit of six months applies to the lodgement of claims with Medicare under the direct-billing (Assignment of Benefits) arrangements. This means that Medicare benefits are not payable for any service where the service was rendered more than six months earlier than the date the claim was lodged with Medicare.
- O7.31 Provision exists whereby in certain circumstances (eg hardship cases, third party or workers' compensation cases), the Minister may waive the time limits. Special forms for this purpose are available, if required, from the processing centre to which assigned claims are directed.

O8. LIMITATIONS ON BENEFITS

Single Course of Attention

- O8.1 A reference to a single course of attention means:-
- (a) In the case of Items [10900](#) to [10918](#) - a course of attention by one or more optometrists in relation to a specific episode of optometric care.
 - (b) In relation to Items [10921](#) to [10930](#) - a course of attention, including all associated attendances, by one or more optometrists for the purpose of prescribing and fitting of contact lenses.

Initial consultations

- O8.2 The initial consultation item (Item [10900](#)) is payable once only within 24 months of the previous standard consultation (Item [10900](#), [10905](#), [10907](#), [10912](#), [10913](#) or [10914](#)). However, a benefit is payable under Item [10912](#), [10913](#) or [10914](#) where the patient has an ocular condition which necessitates a further course of attention being started within 24 months of the previous initial consultation. The conditions which qualify for a further course of attention are contained in the descriptions of these items (see paragraphs [06.16](#) and [06.17](#)).
- O8.3 Where an attendance would have been covered by Item [10900](#), [10905](#), [10907](#), [10912](#), [10913](#), or [10914](#) but is of 15 minutes duration or less, Item [10916](#) (Short consultation) applies.

Second or subsequent consultations (Item [10918](#))

- O8.4 Each consultation, apart from the initial consultation, in a single course of attention, other than a course of attention involving the fitting and prescription of contact lenses, is covered by Item [10918](#).

Contact lens consultations (Items [10921](#) to [10930](#))

- O8.5 In the case of contact lens consultations, benefit is payable only where the patient is one of the prescribed classes of patient entitled to benefit for contact lens consultations as described in Items [10921](#) to [10929](#). For claims under Items [10921](#), [10922](#), [10923](#), [10925](#) and [10930](#), eligibility is based on the patient's distance spectacle prescription, determining the spherical equivalent by adding to the spherical prescription, half the cylindrical correction.
- O8.6 Medicare benefits are not payable for Item [10929](#) in circumstances where patients want contact lenses for:
- (a) reasons of appearance (because they do not want to wear spectacles);
 - (b) sporting purposes;
 - (c) work purposes; or
 - (d) psychological reasons (because they cannot cope with spectacles).
- O8.7 All attendances subsequent to the initial consultation in a course of attention involving the prescription and fitting of contact lenses are collectively regarded as a single service under Items [10921](#) to [10930](#), as appropriate. The date of service is deemed to be the date on which the contact lenses are delivered to the patient. Any visits related to the prescribing and fitting of lenses are regarded to be covered by the [10921](#) to [10930](#). The bulk item includes those aftercare visits necessary to ensure the satisfactory performance of the lenses. This interpretation is unaltered by the frequency of aftercare visits associated with various lens types including extended wear lenses. Consultations during the aftercare period that are unrelated to the prescription and fitting of contact lenses or that are not part of normal aftercare may be billed under other appropriate items (not Items [10921](#) to [10930](#)).
- O8.8 For patients not eligible for Medicare rebates for contact lens care, fees charged for contact lens consultations are a matter between the practitioner and the patient. Any account for consultations involving the fitting and prescription of contact lenses issued to a patient who does not fall into the specified categories should be prepared in such a way that it cannot be used to obtain benefits. No Medicare item number should be attached to any service that does not attract benefits and the optometrist should annotate the account with wording such as "Medicare benefits not payable".
- O8.9 Where an optometrist wishes to apportion the total fee to show the appropriate optometric consultation benefit and the balance of the fee, he or she should ensure that the balance is described in such a way (eg balance of account) that it cannot be mistaken as being a separate consultation. In particular no Medicare item number should be shown against the balance.
- O8.10 When a patient receives a course of attention involving the prescription and fitting of contact lenses an account should not be issued (or an assignment form completed) until the date on which the patient takes delivery of the lenses.
- O8.11 Benefit under Items [10921-10929](#) is payable once only in any period of 36 consecutive months except where circumstances are met under Item [10930](#) within a 36 month period.

Additional payments for optometrists visiting isolated areas (the Visiting Optometrical Scheme)

- O8.12 Special arrangements exist under the provisions of Section 129A of the Health Insurance Act to enable optometrists who visit isolated areas where optometric services are not otherwise available to provide services without additional charge to patients. Optometrists are particularly encouraged to provide these services to Aboriginal and Torres Strait Islander communities in remote areas.
- O8.13 Under these arrangements, assistance may be provided in the form of per capita payments directly related to the numbers of patients attended, with individual rates approved for each applicant who meets the criteria for assistance, in respect of visits to specified locations.
- O8.14 This assistance is provided because the participating nature of the benefit arrangements does not permit optometrists to charge fees higher than Medicare Schedule fees to offset the additional costs involved in visiting remote areas.
- O8.15 Visiting optometrists may obtain application forms for such assistance from the State Manager, Commonwealth Department of Health and Aged Care. Addresses of State offices are located at the end of these Notes.
- O8.16 Visiting optometrists should also note that Regional Eye Health Coordinators located in several Aboriginal Community Controlled Health Services in each State and Territory may be able to assist in arranging and establishing ongoing visits. Optometrists are advised to contact their State Office of the Commonwealth Department of Health and Aged Care.

O9. REFERRALS

General

- O9.1 Optometrists are required to refer a patient for medical attention when it becomes apparent to them that the patient's condition is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.
- O9.2 Optometrists may refer patients directly to specialist ophthalmologists with the patient being able to claim benefits for the ophthalmologist's services at the referred specialist rate.
- O9.3 Optometrists may refer patients directly to another optometrist, based on the clinical needs of the patient.
- O9.4 A referral letter or note must have been issued by the optometrist for all such services provided by specialist ophthalmologists or optometrists in order for patients to be eligible for Medicare benefit at the referred rate. Unless such a letter or note has been provided, benefits will be paid at the unreferred rate.
- O9.5 Medicare benefits at the referred rate are not paid for patients referred by optometrists to consultant physicians or to specialists other than ophthalmologists. See paragraph [O9.13](#) regarding emergency situations.

What is a referral

- O9.6 For the purposes of the optometric arrangements, a "referral" is a request to a specialist ophthalmologist or another optometrist for investigation, opinion, treatment and/or management of a condition or problem of a patient or for the performance of a specific examination(s) or test(s).
- O9.7 Subject to the exceptions in paragraph O9.8 below, for a valid "referral" to take place:
- (i) the referring optometrist must have turned his or her mind to the patient's need for referral and communicate relevant information about the patient to the specialist ophthalmologist or optometrist to whom the patient is referred (but this does not necessarily mean an attendance on the occasion of the referral);
 - (ii) the instrument of referral must be in writing by way of a letter or note and must be signed and dated by the referring optometrist; and
 - (iii) the practitioner to whom the patient is referred must have received the instrument of referral on or prior to the occasion of the professional service to which the referral relates.
- O9.8 The exceptions to the requirements in paragraph O9.7 are that:
- (a) sub-paragraphs (ii) and (iii) do not apply to an emergency situation where the specialist ophthalmologist was of the opinion that the service be rendered as quickly as possible (see para [O9.13](#)); and
 - (b) sub-paragraph (iii) does not apply to instances where a written referral was completed by a referring optometrist but was lost, stolen or destroyed.

Period for which referral is valid

- O9.9 If a referring optometrist wishes that a referral to a specialist ophthalmologist be for a period less than or more than 12 months (eg 3, 6 or 18 months or valid indefinitely), he/she should indicate this to the specialist ophthalmologist.
- O9.10 The referral is valid for the period specified (or 12 months where not otherwise indicated) from the date of the specialist ophthalmologist's first service.
- O9.11 The purpose of permitting a referral for longer than 12 months is to obviate the necessity for a chronically ill patient, who is under the continuing care and management of a specialist for a specific condition(s), to obtain a new referral at the end of each 12 months.

Self referral

O9.12 Optometrists may refer themselves to specialist ophthalmologists or other optometrists and Medicare benefits are payable at referred rates.

Emergency situations

O9.13 In an emergency situation (as defined in the regulations) where the specialist or the consultant physician is of the opinion that the service be rendered as quickly as possible and endorses the account, receipt or assignment form "Emergency referral", Medicare benefits are payable even though there is no written referral. This provision only applies to the initial attendance. For subsequent attendances to attract benefits at the referred rate a referral must be obtained from a medical practitioner or, in the case of a specialist ophthalmologist, a medical practitioner or an optometrist.

O10. PROVISION FOR REVIEW AND INQUIRY

Optometric Benefits Consultative Committee (OBCC)

O10.1 The OBCC is an advisory committee established in 1990 by arrangement between the Minister and the Optometrical Association Australia.

O10.2 The OBCC's functions are:

- (i) to consider the appropriateness of existing Medicare Benefits Schedule items, including the need to combine, delete or create items, and the need to amend item descriptions;
- (ii) to undertake reviews of particular services and to report on the appropriateness of the existing structure of the Schedule, having regard to current optometric practice;
- (iii) to provide a forum for the discussion on fees and fee relativities for individual optometric items in the Medicare Benefits Schedule (but not so as to involve a general review of the overall level of optometric fees);
- (iv) to consider and advise on the appropriateness of the participating optometrists' arrangements and the Common Form of Undertaking (as specified in the Health Insurance Act and related legislation) and the administrative rules and interpretations which determine the payment of benefits for optometric services or the level of benefits;
- (v) to investigate specific matters associated with the participating optometrists' arrangements and to advise on desirable changes.

O10.3 The OBCC comprises two representatives from the Department of Health and Aged Care, two representatives from the Health Insurance Commission, and three representatives from the Optometrical Association Australia.

Professional Services Review (PSR) Scheme

O10.4 The Professional Services Review (PSR) Scheme provides for a system of peer review to determine whether a practitioner has inappropriately rendered or initiated services which attract a Medicare benefit, or has inappropriately prescribed under the Pharmaceutical Benefits Scheme (PBS). A practitioner includes an optometrist.

O10.5 Section 82 of the Health Insurance Act 1973 defines inappropriate practice as conduct that is such that a PSR Committee could reasonably conclude would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.

O10.6 From 1 August 1999, changes were introduced to improve the administration of the PSR Scheme. These include increased investigation, case preparation and negotiation powers for the Director of PSR and greater legal support for the person under review. The PSR Tribunals have also been removed from the process whilst retaining the right of review on points of law.

O10.7 Under the PSR Scheme, the decision to establish a PSR Committee is made by the independent Director of PSR after receiving an investigative referral for the review of a practitioner's conduct from the Health Insurance Commission.

O10.8 When an investigative referral is made, the Director of PSR must conduct an investigation, in such manner as he or she thinks appropriate, into the referred services, including services not dealt with in reasons given by the Commission for the referral. The Director has the power to require the production of documents or the giving of information.

O10.9 The Director also has the power to dismiss an investigative referral, set up a PSR Committee, negotiate a written agreement with the practitioner, or take no action.

O10.10 The various methods available to a PSR Committee to investigate and quantify inappropriate practice have been clarified. In addition to examining identified services, the legislation now provides for the following methodologies:

- Patterns of Services - Where a practitioner reaches or exceeds a volume of services specified in regulations, he or she is deemed to have practised inappropriately. The quantum of that inappropriate practice can be reduced if the PSR Committee is satisfied that the practitioner has demonstrated exceptional circumstances in respect of any day or days on which services were rendered.

- Sampling - A PSR Committee can apply a statistically valid sampling methodology to examine the conduct of a practitioner in relation to particular identifiable services and to extrapolate the results to a larger number of similar services within the referral period.
- Generic findings - If a PSR Committee cannot conduct its inquiry using the patterns of services or sampling provisions, it can make a generic finding of inappropriate practice. This will apply where a PSR Committee is unable to obtain sufficient clinical or practice records from the practitioner to conduct its investigation.

- O10.11 In determining whether a practitioner has engaged in inappropriate practice, from 1 November 1999 a PSR Committee is also required to have regard to whether or not the practitioner kept adequate and contemporaneous patient records. The standards which a record must meet to constitute an adequate and contemporaneous record are prescribed in regulations. A record should be completed at the time that the service was provided or as soon as practicable afterwards. It should be sufficient to contribute to the quality and continuity of the patient's care. It should be clear and detailed enough to enable another practitioner to undertake the ongoing care of the patient. The record should also identify the service that was provided.
- O10.12 If a Professional Services Review Committee finds that an optometrist has engaged in inappropriate practice, a determination must be made that the optometrist be: reprimanded; counselled; ordered to repay to the Commonwealth the whole or part of the Medicare benefits paid for the services; the optometrist's undertaking be revoked either wholly or in relation to particular premises and/or partially or fully disqualified from Medicare.
- O10.13 The new PSR arrangements apply in relation to new cases referred by the HIC to the Director of PSR after 1 August 1999. Existing cases will be dealt with under the previous arrangements.
- O10.14 Appeals against the Minister's decision to reject an application to become a Participating Optometrist may be made to the Administrative Appeals Tribunal.

O11. PENALTIES AND LIABILITIES

Penalties

- O11.1 Penalties of up to \$10,000 or imprisonment for up to five years may be imposed on any person who makes a statement (either orally or in writing) or who issues or presents a document that is false or misleading in a material particular and which is capable of being used in connection with a claim for benefits. In addition, any practitioner who is found guilty of such offences shall be subject to examination by a Medicare Participation Review Committee and may be counselled or reprimanded or may have services wholly or partially disqualified from the Medicare benefit arrangements.
- O11.2 A penalty of up to \$1,000 or imprisonment for up to three months, or both, may be imposed on any person who obtains a patient's signature on a direct-billing form without the necessary details having been entered on the form before the patient signs or who fails to give the patient a copy of the completed form.

Medicare Participation Review Committee (MPRC)

- O11.3 The Medicare Participation Review Committee determines what administrative action should be taken against a practitioner who has been successfully prosecuted for defrauding Medicare.
- O11.4 The Committees have a discretionary range of options from taking no action against the practitioner through counselling and reprimand to full or partial disqualification from participating in the Medicare benefit arrangements for up to five years.

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING

(Postal : GPO Box 9848 in each Capital City)

NEW SOUTH WALES

Level 7
1 Oxford Street
SYDNEY 2000 Tel (02) 9263 3555

VICTORIA

Casselden Place
2 Lonsdale Street
MELBOURNE 3000 Tel (03) 9665 8888

QUEENSLAND

5th Floor
Samuel Griffith Building
340 Adelaide Street
BRISBANE 4000 Tel (07) 3360 2555

SOUTH AUSTRALIA

Commonwealth Centre
55 Currie Street
ADELAIDE 5000 Tel (08) 8237 8111

WESTERN AUSTRALIA

152-158 St George's Terrace
PERTH 6000 Tel (08) 9346 5111

TASMANIA

Montpelier Building
21 Kirksway Place
BATTERY POINT 7004 Tel (03) 6221 1411

AUSTRALIAN CAPITAL TERRITORY

Alexander Building
Furzer Street
PHILLIP 2606 Tel (02) 6289 1555

NORTHERN TERRITORY

Cascom Centre
13 Scaturchio Street
CASUARINA 0800 Tel (08) 8946 3444

HEALTH INSURANCE COMMISSION

(Postal : Medicare, GPO Box 9822, in each Capital City, Phone Enquiries on 132 150)

NEW SOUTH WALES

State Headquarters Colonial
Tower
150 George Street
PARRAMATTA NSW 2150 Tel (02) 9895 3333

VICTORIA

Medibank House
460 Bourke Street
MELBOURNE 3000 Tel (03) 9605 7333

QUEENSLAND

State Headquarters
444 Queen Street
BRISBANE 4000 Tel (07) 3004 5333

SOUTH AUSTRALIA

State Headquarters
209 Greenhill Road
EASTWOOD 5063 Tel (08) 8274 9333

WESTERN AUSTRALIA

State Headquarters
11th Floor
Bank West Tower
108 St. George's Terrace
PERTH 6000 Tel (08) 9214 8333

TASMANIA

State Headquarters
242 Liverpool Street
HOBART 7000 Tel (03) 6215 5333

AUSTRALIAN CAPITAL TERRITORY

134 Reed Street
TUGGERANONG 2901 Tel (02) 6124 6333

NORTHERN TERRITORY

As per South Australia

SECTION 2

SCHEDULE OF SERVICES

ATTENDANCES	ATTENDANCES
GROUP A10 - OPTOMETRIC CONSULTATIONS	
10900	<p>COMPREHENSIVE INITIAL CONSULTATION</p> <p>Professional attendance of more than 15 minutes duration, being the first in a course of attention - not payable within 24 months of an attendance to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit:85% = \$48.95</p>
10905	<p>REFERRED COMPREHENSIVE INITIAL CONSULTATION</p> <p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has been referred by another optometrist who is not associated with the optometrist to whom the patient is referred <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit:85% = \$48.95</p>
10907	<p>COMPREHENSIVE INITIAL CONSULTATION BY ANOTHER PRACTITIONER WITHIN 24 MONTHS OF A PREVIOUS COMPREHENSIVE CONSULTATION</p> <p>Professional attendance of more than 15 minutes duration being the first in a course of attention where the patient has attended another optometrist within the previous 24 months for an attendance to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$28.85 Benefit:85% = \$24.55</p>
10912	<p>OTHER COMPREHENSIVE CONSULTATIONS</p> <p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has suffered a significant change of visual function requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 at the same practice applied <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit:85% = \$48.95</p>
10913	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has new signs or symptoms, unrelated to the earlier course of attention, requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 at the same practice applied <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit:85% = \$48.95</p>
10914	<p>Professional attendance of more than 15 minutes duration, being the first in a course of attention, where the patient has a progressive disorder (excluding presbyopia) requiring comprehensive reassessment within 24 months of initial consultation to which item 10900, 10905, 10907, 10912, 10913 or 10914 applied <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$57.55 Benefit:85% = \$48.95</p>
10916	<p>BRIEF INITIAL CONSULTATION</p> <p>Professional attendance, being the first in a course of attention, of not more than 15 minutes duration <i>(See para O1 of explanatory notes to this Category)</i> Fee: \$28.85 Benefit:85% = \$24.55</p>
10918	<p>SUBSEQUENT CONSULTATION</p> <p>Professional attendance being the second or subsequent in a course of attention not related to the prescription and fitting of contact lenses Fee: \$28.85 Benefit:85% = \$24.55</p>

SECTION 3

COMMON FORM OF UNDERTAKING

Common Form of Undertaking

Participating Optometrists

Sections 23A and 23B Health Insurance Act 1973

For the purposes of section 23A of the *Health Insurance Act 1973* (the Act) I,
_____ (full name in BLOCK letters)

of _____ (address for correspondence)

being

an optometrist registered to practice optometry in a State or Territory of Australia; or

a person/s who employs optometrists to provide services in the course of the practice of their profession; or

both of the above

(Choose one of the above options by marking a cross in the appropriate box)

who wishes to become a Participating Optometrist, hereby give the following undertaking to the Minister for Health and Aged Care for and on behalf of the Commonwealth of Australia.

(Where this undertaking is made on behalf of a company or partnership which employs optometrists, it should be signed by a person who has the authority to make such undertakings on behalf of the company or, in the case of a partnership, by one of the partners on behalf of the partnership)

INTRODUCTION

1 The Minister has, pursuant to subsection 23A(1) of the Act, after consultation with the Australian Optometrical Association, drawn up a common form of Undertaking to be given by an optometrist who wishes to become a Participating Optometrist. Definitions, interpretation and other formalities relating to this Undertaking are at Schedule 1.

2 *Date on which an Undertaking comes into force*

2.1 An Undertaking comes into force on the day on which it is accepted by the Minister.

3 *Services to which this Undertaking relates*

3.1 This Undertaking relates to any clinically relevant service ordinarily rendered by an optometrist in relation to consultation on ocular or vision problems, but does not include:

- (a) an attendance for the sole purpose of delivering a prescribed visual aid or appliance or adjusting or repairing such an aid or appliance;
- (b) an attendance for the purpose of filling a prescription written by another practitioner;
- (c) an attendance on behalf of teaching institutions on patients of supervised students of optometry;
- (d) an attendance by an optometrist on:
 - (i) any dependant of the Optometrist;
 - (ii) a practice partner of the Optometrist or any dependants of that partner;
 - (iii) an employer of the Optometrist or any dependants of that employer;
- (e) anything done or service provided at any premises other than those specified in this Undertaking.

4 *Premises to which this Undertaking relates*

4.1 Where this Undertaking is signed by a person/s who employs optometrists to provide services in the course of the practice of optometry, the premises to which this Undertaking relates are those:

- (a) specified in Schedule 2; and
- (b) any other premises at which a domiciliary visit is made.

5 *Termination of Undertaking*

5.1 This Undertaking shall continue to be in force until it is:

- (i) terminated by the Optometrist under subsection 23B(6) of the Act; or
- (ii) revoked by the Minister following a determination of fraudulent or inappropriate practice.

5.2 A Participating Optometrist may, at any time, terminate an Undertaking, either wholly or in so far as it covers particular premises, by serving, as prescribed, a notice of termination to the Managing Director, Health Insurance Commission, specifying a date of termination not earlier than 30 days after the day on which the notice is served.

UNDERTAKING

6 *Fees*

- 6.1 I undertake to charge fees which do not exceed the Medicare Schedule fee for any service to which this Undertaking and a Medicare item apply, except in the case of:
- (i) a domiciliary visit where an additional fee not exceeding the Medicare Schedule fee for Item 10900 may apply; and
 - (ii) a patient being billed an Item 10907 attendance where an additional fee not exceeding an amount equal to the difference between the Medicare Schedule fee for Item 10900 and Item 10907 may apply. The appropriate fee for patient billing purposes in such cases should not exceed the Medicare Schedule fee for Item 10900.
- 6.2 I undertake that when I charge an additional fee as specified in subclause 6.1(ii), I will inform the patient of the Medicare benefit payable for Item 10907, at the time of the consultation, and that the additional fee will not attract benefits.
- 6.3 I undertake that I will obtain the patient's informed consent to the release of information to me if it is necessary for me to seek patient information from the Health Insurance Commission in order to determine appropriate itemisation of accounts, receipts or bulk-billed claims.
- 6.4 I undertake that I will not include an amount that relates to a service to which this Undertaking and a Medicare item apply in any charge made for appliances.
- 6.5 I undertake that I will not include a fee for a visit made or a service provided which is not a service to which this Undertaking applies in any charge made in respect of a Medicare item.

7 *Billing procedures*

- 7.1 I undertake to issue a receipt, or an account and a receipt, as the case may require, for all attendances made by myself, or on my behalf, to which a Medicare item applies, except where an assignment of benefit is made in accordance with section 20A of the Act.
- 7.2 I undertake that any receipt or account issued as provided in subclause 7.1 will contain the details of:
- (a) any additional fee for a domiciliary visit where applicable (subclause 6.1(i));
 - (b) any additional fee in respect of Item 10907 (subclause 6.1(ii)); and
 - (c) the particulars prescribed in regulations made from time to time pursuant to subsection 19(6) of the Act.
- 7.3 I undertake that I will ensure that no fee is charged, nor an assignment of benefit made under section 20A of the Act for an attendance to which one of Items 10921-[10930](#) inclusive relates before the date on which the patient takes delivery of the contact lenses.
- 7.4 I undertake that I will ensure that in respect of each service:
- (a) only one original of the receipt or account is issued; and
 - (b) where a duplicate receipt or account is issued it is clearly marked "duplicate".

- 7.5 I undertake that I will take all reasonable steps to ensure that all items are billed in accordance with this Undertaking and the appropriate Medicare items.
- 7.6 I undertake to accept the relevant Medicare benefit as full payment for the consultation where an assignment of benefit is made in accordance with section 20A of the Act. I accept that additional charges for that service (irrespective of the purpose or title of the charge) **cannot** be raised against the patient, including the special circumstances relating to domiciliary visits and consultations covered under Item 10907.

8 Referral

- 8.1 I undertake that I will ensure that a patient is referred to a medical practitioner when it becomes apparent to the Attending Optometrist that the condition of the patient is such that it would be more appropriate for treatment to be undertaken by a medical practitioner.
- 8.2 I undertake that I will refer patients to other optometrists solely on the basis of the clinical needs of the patient.

9 Prescriptions

- 9.1 I undertake that I will ensure that patients are informed that they are entitled to a copy of their spectacle prescription, and that they are free to have the prescribed spectacles dispensed by any person of their choice.
- 9.2 I undertake that I will ensure that where a contact lens prescription is prepared for the patient, the contact lens prescription is available to the patient at the completion of the prescription and fitting process.

10 Recalls

- 10.1 I undertake that any notice sent to a patient by me or on my behalf suggesting re-examination will be sent solely on the basis of the clinical needs of the patient.

11 Advertising

- 11.1 I undertake that I will not advertise or allow any person to advertise on my behalf in a manner that would lead to claims for Medicare benefits for services that are not Clinically Relevant Services as defined in the Act.

12 Notification of changes in practice details

- 12.1 I/we, as an employer of optometrists, undertake that in the event of a change in, or addition to, the details of the practice, as set out in Schedule 2, I/we will provide the Health Insurance Commission with details of the change or addition within 28 days of the change or addition.

13 Supply of Information

- 13.1 I undertake to furnish to the Minister such information relating to the rendering of services by, or on behalf of, the Optometrist as is from time to time reasonably requested by the Minister.

[Signature]

[Date]

[Witnesses]

Schedule 1

Definitions, Interpretation and Other Formalities

1

Definitions

In this Undertaking:

- (a) **"Act"** means the *Health Insurance Act 1973*;
- (b) **"Attending Optometrist"** means an optometrist as defined in subsection 3(1) of the Act, who renders the service;
- (c) **"Clinically Relevant Service"** means a service rendered by an optometrist that is generally accepted in the optometrical profession as being necessary for the appropriate treatment of the patient to whom it is rendered;
- (d) **"Commonwealth"** means the Commonwealth of Australia;
- (e) **"Department of Health and Aged Care"** means the Commonwealth Department of Health and Aged Care or, where the subject matter of the Undertaking is transferred to another Commonwealth Department or Agency, that other Department or Agency;
- (f) **"Domiciliary Visit"** means a professional attendance to which an item in the General Medical Services Table relates, given at the request of patients, either at their place of residence or at a nursing home, hospital or other temporary place of residence of the patient;
- (g) **General Medical Services Table** means a table of medical services prescribed under section 4 of the Act in the Regulations, as varied from time to time;
- (h) **Medicare benefit** means a benefit payable by the Commonwealth in relation to a professional service to which Medicare item applies;
- (i) **Medicare item** means an item specified in the General Medical Services Table;
- (j) **Medicare Schedule fee** means a fee specified for a Medicare item;
- (k) **"Minister"** means the Minister responsible for administering the Department of Health and Aged Care and includes:
 - (i) any other Minister of the Commonwealth of Australia who is for the time being acting for that Minister;
 - (ii) a person to whom the relevant powers or functions of the Minister are for the time being delegated;
- (l) **"Optometrist"** for the purposes of sections 23A and 23B of the Act, includes a person who employs optometrists to provide services in the course of the practice of their profession;
- (m) **"Participating Optometrist"** means an optometrist or other person in respect of whom there is in force an Undertaking given by that person and accepted by the Minister under section 23B of the Act;
- (n) **"Person"** includes a body politic or corporation as well as an individual;
- (o) **"Service"** means a professional service specified in a Medicare item that relates to an attendance by a Participating Optometrist;

- (p) **"Undertaking"** means this Common Form of Undertaking and any Schedules hereto as each may be amended from time to time.

2

Interpretation

In this Undertaking, unless contrary intention appears:

- (a) a reference to a clause refers to the relevant clause to this Undertaking;
- (b) a reference to a Schedule is to the relevant Schedule of this Undertaking and if a Schedule is at any time varied extends to the Schedule as so varied;
- (c) words in the singular include the plural and words in the plural include the singular;
- (d) the terms I and me refer to the company or the body corporate where a company or a body corporate is making an undertaking; and
- (e) words and expressions used in the Undertaking have the meaning given to them in Schedule 1 of the Undertaking and the Act.

3

Operation of Undertaking

If the Act or the Regulations are amended this Undertaking will be read as amended to comply with the then current form of the Act or Regulations.

Any amendments to the Undertaking will be notified in writing to the Optometrist within 28 days of their coming into force or on such earlier day specified by the Minister not being a day earlier than the day on which the amendment was received by the Health Insurance Commission.

4

Variation of Undertaking

This Undertaking is subject to variation as provided in subsections 23A(3) and 23B(5) of the Act.

5

Notices

Any notice or other communication to the Optometrist under, or for the purpose of, this Undertaking by the Minister shall be deemed to have been duly given or made if it is in writing signed by or on behalf of the Minister or in the case of a delegate signed by that delegate and is sent by prepaid post addressed to the Optometrist at the address shown in Schedule 3 for the forwarding of notices or at such other address as is notified in writing, from time to time, by the Optometrist to the Minister or his delegate for that purpose.

Any notice, or other communication to the Minister under, or for the purpose of, this Undertaking by the Optometrist shall be deemed to have been duly given or made if it is in writing, signed by or on behalf of the Optometrist, addressed to the Minister and is served personally or by being sent by prepaid post, addressed to the Manager, Health Insurance Commission in the State in which the premises to which the Undertaking applies are situated. If the premises are situated in the Australian Capital Territory or the Northern Territory, the notice is to be addressed to the General Manager, Health Insurance Commission, PO Box 1001, Tuggeranong ACT 2901.

A notice, or other communication sent by post shall be deemed to have been received by the Optometrist or the Minister as the case may be, when it would have been delivered in the ordinary course of mail delivery.

Schedule 2
Premises to which this Undertaking relates

The premises specified for the purposes of this Undertaking are located at:

[Address 1]
[Address 2]
[Address 3]
[Etc]

Schedule 3

Address for correspondence

Notices or other communications to the Optometrist relating to this Undertaking should be directed to:
[Name & Address]