SUPPLEMENT TO 1 NOVEMBER 2002 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 MAY 2003

This supplement provides details of changes to the 1 November 2002 edition of the Medicare Benefits Schedule. With the exception of deleted items, any item not included in this supplement remains as it is shown in the 1 November 2002 Schedule.

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

SAFETY NET

The Medicare "safety net" increased to $319.70 with effect from 1 January 2003 (see para 1.1 of General Explanatory Notes to the 1 November 2002 Medicare Benefits Schedule for details of the safety net).

AMENDMENTS TO GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- **Professional Services Review -** General Explanatory Note 8.1 has been amended to reflect revised administrative arrangements introduced from 1 January 2003.
- **Acupuncture** - Two new items (items 197 and 199) have been added for attendances by general practitioners at which acupuncture is performed. The items are equivalent to Level C (item 36) and Level D (item 44) to cover the longer consultations and reflect more appropriately the wide variety of interventions which take place during a general practice consultation at which acupuncture is performed. The Professional Attendances Explanatory Notes have been amended at A5 and A14 to include references to these new items.
- **Multifocal Multichannel Objective Perimetry (MMOP)** - Following a Medical Services Advisory Committee (MSAC) assessment of MMOP it was recommended that public funding not be supported for MMOP at this time, therefore medical benefits are not payable for any MMOP procedures. A restriction has been placed on the items 11024, 11027, 11221, 11222, 11224 and 11225 to exclude the use of MMOP.
- **Ophthalmology** - The fee for item 106 has been increased to $57.55 from 1 May 2003 to bring it into alignment with the fees for the equivalent optometrical consultation items. There are minor amendments to the descriptors and explanatory notes for computerised perimetry items 11222 and 11225, to clarify the circumstances under which benefits can be claimed for those items.
- **Vascular Investigations** - Items 11603, 11606 and 11609 have been amended to clarify that these items, which are diagnostic items, should not be used in conjunction with sclerotherapy (echosclerotherapy).
- **Urodynamics -** Item 11919 has been created and item 11918 deleted to ensure the correct use of items and to assist in data collection for the types of diagnostic imaging services being performed. The item descriptors (11900, 11903, 11906, 11909, 11912, 11915, 11917) containing references to 11918 have been amended accordingly. The descriptors in items 11917 and 11919 have been amended to reflect the text contained in items 11917 and 11918 in the *Health Insurance (General Medical Services Table) Regulations 2002.*
- **Radiation Oncology Megavoltage items** - Items 15203, 15204, 15207 and 15208 have been deleted. Effectively, each item has been replaced by five items which now include details of the key cancer types.
- **Therapeutic dose of Yttrium 90 (Item 16003)** - Following an MSAC assessment of Selective Internal Radiation Therapy (SIRT) for hepatic metastases, the therapeutic dose of Yttrium 90 item (item 16003) has been amended to exclude its use for the SIRT procedure. Medicare benefits are not payable for SIRT under any item.
- **Botulinum Toxin** - New items have been introduced and several amendments have been made to existing items to cover the treatment of specific conditions with botulinum toxin. The indications for treatment must be initially approved by the Therapeutic Goods Administration (TGA).
  - All botulinum toxin items will be grouped together in Group T7.
  - Items 18350, 18352, 18354, 18356 and 18358 have been introduced to cover specific indications which have TGA approval.
  - Item 42827, blepharospasm, has been renumbered to 18370 and transferred to Group T7.
  - Items 42830, strabismus and 41869, vocal chords have been deleted from the Schedule and will be claimable under a Section 3C Ministerial Determination as the treatment of these conditions with botulinum toxin has not been approved by the TGA. The Determination will be for a period of three years (or until TGA approval is granted) to allow continued access to the items.
  - All items have been restricted to the brand of botulinum toxin which has been approved by the TGA ie; Botox or Dysport.
  - Items 18290 and 18292 have been amended to exclude the use of botulinum toxin. New explanatory notes have been included at T7.4.

- **Anaesthesia -** Four new items (20440, 21112, 21114 and 21116) have been introduced into the Relative Value Guide for Anaesthetics to cover percutaneous trephine bone marrow biopsy of the pelvis and sternum, to differentiate these from the more complex open procedures.
- **Skin Lesion items -** The descriptors for items 31205-31240, 31250, 31255-31335, 31345 and 31350 have been amended to clarify the intention of the items, where the specimen excised must be sent for histological examination and if required, confirmation of malignancy obtained.
- **Breast surgery items** - Items 31500, 31503, 31506, 31509, 31512, 31515, 31536, 31539, 31542 and 31545 have had minor amendments to the item descriptor to align with the description of the service in the *Health Insurance (General Medical Services Table) Regulations 2002.*
- **Vascular procedures -** Items 32500 and 32501 have been amended to clarify that it is sclerosant which is being injected, and item 32501 has been further amended to clarify that, before the item can be used, it is necessary to demonstrate that truncal reflux in the long or short saphenous veins does not exist on duplex examination.
- **Percutaneous Transluminal Coronary Rotational Atherectomy (PTCRA) -** The Medical Services Advisory Committee (MSAC) has assessed PTCRA and found the procedure to be effective for the following specific indications:
  a) Revascularisation of complex and heavily calcified coronary artery lesions which cannot be treated by percutaneous transluminal coronary angioplasty (PTCA) alone or when previous PTCA attempts have not been successful; and
  b) Revascularisation of complex and heavily calcified coronary artery stenoses where coronary artery bypass graft (CABG) surgery is contra-indicated.

  New items have been created to allow benefits to be claimed for PTCRA (items 35335, 35338, 35341, 35344). New Note T8.34 also added.
- **Urological items** - The deletion of item 36839 and the introduction of two new items 36840 and 37224 which will allow for billing of prostate treatment by TURP or TUNA in conjunction with bladder tumour treatments, if appropriate. Amendments to descriptors and associated notes for cystoscopy item 36836 have been made as a result of the deletion of 36839

- **Plastic Surgery** - Digital photographs are now acceptable to the Medicare Claims Review Panel (MCRP) providing the practitioner signs and certifies that the image has in no way been altered.
  - A definition of the terms "superficial" and "deeper tissues" for items 30026 to 30049 has been introduced.
  - Amendments to descriptors for items 30195 to 30205 replacing the word "cancer" with "neoplasm"(benign or malignant) have been made for consistency within the MBS.
  - Lipectomy items 30165 and 30177 and associated notes have been amended to restrict use in patients within 12 months after the most recent pregnancy.
  - Amendments to descriptors and associated notes for mammaplasty, meloplasty and rhinoplasty items 45528, 45588 and 45638 now exclude their use for correction of trauma from previous cosmetic surgery.
  - Amendments to descriptors and associated notes for breast ptosis items 45557 and 45558 define the correction method (mastopexy) and restrict the use of items to patients between 12 months and within seven years after the most recent pregnancy to allow for appropriate billing.
  - Amendments to the descriptor for liposuction item 45585 clarifies the use of the item for patients with Barraquer-Simon's syndrome, gynaecomastia and lymphoedema only. Also, liposuction items 31346 and 45586 have been introduced for patients with contour problems of the stomach due to insulin injections and buffalo hump resulting from endocrine disorder or pharmacological treatment.
- **Lumbar Discectomy -** Following an MSAC assessment of Intradiscal Electrothermal Annuloplasty (IDETA), lumbar discectomy, item 48636 has been amended to restrict its use to exclude the IDETA procedure. Medicare benefits are not payable for IDETA under any item.
- **Cleft Lip and Cleft Palate** - Following an amendment to the *Health Insurance Act 1973,* the criteria for patient eligibility for services under the Medicare Cleft Lip and Cleft Palate Scheme has been extended for eligible patients requiring ongoing treatment.

SUMMARY OF CHANGES

The 1 May 2003 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) new reference to note

New Items

197	199	11919	15215	15218	15221	15224	15227	15230	15233	15236
15239	15242	15245	15248	15251	15254	15257	15260	15263	15266	15269
15272	18350	18352	18354	18356	18358	18370	20440	21112	21114	21116
31346	35335	35338	35341	35344	36840	37224	45586	66750	66751	73300
73305										

Deleted Items

11918	15203	15204	15207	15208	41869	42830	36839	42827	66746	66740
69342	69348	69351								

Amended Description

11024	11027	11221	11222	11224	11225	11603	11606	11609	11900	11903
11906	11909	11912	11915	11917	16003	18290	18292	30195	30196	30197
30202	30203	30205	31205	31210	31215	31220	31225	31230	31235	31240
31250	31255	31260	31265	31270	31275	31280	31285	31290	31295	31300
31305	31310	31315	31320	31325	31330	31335	31345	31350	31500	31503
31506	31509	31512	31515	31536	31539	31542	31545	32500	32501	36836
						45528	45557	45558	45585	45588
45638	48636	55808	55810	55828	55830	65117	66650	66743	69318	69336
69339	69345	69363	69405	69408	69411	73287	73289			

Fee Amended

106	69315	69336	69339

Item Number Change

Old	New	Old	New
11918	11919	42827	18370

New References to Note T8.12

30165	30177

SPECIAL ARRANGEMENTS - TRANSITIONAL PERIOD

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

If the item refers to a service in which treatment continues over a period of time in excess of one day and the treatment commenced before 1 May 2003 and continues beyond that date, the old (1 November 2002) item, fee and benefit levels will apply. In any other case the date the service is rendered will determine which item and fee is applicable.

8.1 Professional Services Review (PSR) Scheme

8.1.1 The Professional Services Review (PSR) Scheme is a scheme for reviewing and investigating the provision of services by a health practitioner to determine whether the practitioner has engaged in inappropriate practice in the rendering or initiating of Medicare services or in prescribing under the Pharmaceutical Benefits Scheme (PBS). A health practitioner is a medical practitioner, a dentist, an optometrist, a chiropractor, physiotherapist or a podiatrist.

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 that it 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 The Health Insurance Commission (HIC) monitors health practitioners claiming patterns. Where an anomaly is detected, for which a satisfactory explanation cannot be provided, the HIC can request that the Director of PSR review the provision of services by the practitioner.

8.1.4 From 1 January 2003, several changes were introduced to clarify each stage in the PSR process, and to strengthen the procedural fairness provisions available to the person under review.

8.1.5 Under the revised PSR arrangements, the decision to establish a PSR Committee is made by the independent Director of PSR after receiving a request from the HIC for a review of the provision of services by a person (previously this was an investigative referral).

8.1.6 When a request for a review is made, the Director of PSR must decide whether to conduct a review. If a review is carried out into the provision of services specified in the referral, it can be done in such manner, as the Director thinks appropriate. The Director has the power to require the production of documents or the giving of information.

8.1.7 Following a review, the Director must:

- decide to take no further action in relation to the review; or
- enter into an agreement with the person under review (which must then be ratified by an independent Determining Authority before it can take effect); or
- make a referral to a PSR Committee.

8.1.8 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.

8.1.9 A referral to a PSR Committee (previously this was an adjudicative referral) initiates an investigation by the Committee into the provision of the services specified in the referral. The Committee can investigate any aspect of the provision of the referred services and its investigation is not limited by any reasons given in a request for review or a Director's report following a review.

8.1.10 Committees can hold hearings and require the person under review to attend and give evidence. Committees also have the power to require the production of documents (including clinical notes).

8.1.11 The various methods available to a PSR Committee to investigate and quantify inappropriate practice are specified in legislation.

- 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 Regulations 1999 (No. 1),* as amended, is 80 or more professional attendances on each of 20 or more days in a 12-month period.
- A professional attendance includes a service of a kind mentioned in group A1, A2, A5, A6, A7, A11, A13, A14 or A15 of Part 3 of the *Health Insurance (General Medical Services Table) Regulations 2002*.
- Where a practitioner can demonstrate to the satisfaction of a PSR Committee that exceptional circumstances exist, the quantum of inappropriate practice is reduced accordingly. Matters that constitute exceptional circumstances include, but are not limited to, those set out in the Regulations. These include:

    - 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).

- 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.

8.1.12 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.).
8.1.13 Provision is made throughout the Scheme for the person under review to make submissions before key decisions are made or final reports are given.
8.1.14 Under the revised arrangements, a Committee cannot make a finding of inappropriate practice unless it has given the person under review: notice of its intention to do so; and the reasons for the findings; and an opportunity to respond.
8.1.15 If a Committee finds that the person under review has engaged in inappropriate practice, the findings will be reported to the Determining Authority. The Determining Authority decides what action to take. Such action can include: a reprimand; counselling; repayment of Medicare benefits; and/or complete or partial disqualification from the Medicare Scheme for up to three years.
8.1.16 The revised PSR arrangements apply in relation to requests by the HIC to the Director of PSR made after 1 January 2003. Existing cases will be dealt with under the previous arrangements.
8.1.17 Further information is available from the PSR website, www.psr.gov.au.

A.5 Attendances by General Practitioners (Items 1-51, 193, 195, 197, 199, 601, 602, 2501 - 2559)

A.5.1 Items 1 to 51 and 193, 195, 197, 199, 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

A.14 Acupuncture (Item 173, 193, 195, 197 and 199)

A.14.1 The service of "acupuncture" must be performed by a medical practitioner and itemised under item 173, 193, 195, 197 or 199 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, 195, 197 and 199 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.

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 and where there has been definite progression of damage over a 12 month period;
- established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or
- for monitoring ocular disease caused by systemic drug toxicity, where there is also other disease such as glaucoma or neurological 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 8.6 of the General Explanatory Notes.)

D1.5 Multifocal Multichannel Objective Perimetry (Items 11024, 11027, 11221, 11222, 11224 and 11225)

D1.5.1 Following an MSAC assessment of Multifocal Multichannel Objective Perimetry (MMOP), it was recommended that public funding not be supported for MMOP at this time therefore medical benefits are not payable for any MMOP procedures.

D1.5.2 A restriction has been placed on the items 11024, 11027, 11221, 11222, 11224 and 11225 to exclude the use of MMOP and those items should not be claimed for MMOP.

D1.12 Investigations of Vascular Disease (Items 11603-11624)

D1.12.1 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.

D1.12.2 Items 11603, 11606 and 11609, which are diagnostic items, should not be used in conjunction with sclerotherapy (echosclerotherapy).

T7.4 Botulinum Toxin (Items 18350 - 18358, 18370)

T7.4.1 The Therapeutic Goods Administration (TGA) assesses each indication for the therapeutic use of botulinum toxin on an individual basis. There are currently two botulinum toxin agents with TGA registration (Botox and Dysport). Each has undergone a separate evaluation of its safety and efficacy by the TGA as they are not bioequivalent, nor dose equivalent. When claiming under an item for the injection of botulinum toxin, only the botulinum toxin agent specified in the item can be used. Benefits are not payable where an agent other than that specified in the item is used.

T7.4.2 The TGA assesses each indication for the therapeutic use of botulinum toxin by assessment of clinical evidence for its use in paediatric or adult patients. Where an indication has been assessed for adult use, data has been assessed using patients over 12 years of age. Paediatric indications have been assessed using data from patients under 18 years of age. Botulinum toxin should only be administered to patients under the age of 18 where an item is for a paediatric indication, and patients over 12 years of age where the item is for an adult indication.

T7.4.3 Items for the administration of botulinum toxin can only be claimed by a medical practitioner who is registered by the Health Insurance Commission to participate in the arrangements under Section 100 of the *National Health Act 1953* relating to the use and supply of Botulinum Toxin.

T7.4.4 Items 18354, 18356 and 18358 for the treatment of equinus, equinovarus or equinovalgus are limited to a maximum of four treatments per patient on any one day (two per limb). Accounts should be annotated with the limb which has been treated.

T8.8 Therapeutic dose of Yttrium 90 (Item 16003)

T8.8.1 Following a Medical Services Advisory Committee (MSAC) assessment of the Selective Internal Radiation Therapy (SIRT) for hepatic metastases procedure, there was found to be insufficient evidence to support public funding of this procedure at this time. A restriction has been placed on the item 16003 and this item cannot be claimed for SIRT.

T8.12 Lipectomy (Item 30165, 30171, 30177)

T8.12.1 Multiple lipectomies, eg, both buttocks and both thighs attract benefits under item 30171 once only, ie 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.

T8.12.2 Lipectomy items 30165 and 30177 may not be claimed for patients if performed within 12 months after the most recent pregnancy.

T8.14 Cryotherapy and Serial Curettage Excision (Items 30196 - 30203)

T8.14.1 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.

T8.14.2 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.

T8.21 Removal of Skin Lesions (Items 31200 - 31355)

T8.21.1 The excision of warts and seborrheic keratoses attracts benefits on an attendance basis. Pre-malignant lesions are covered by items 31200 to 31240.

T8.21.2 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.

T8.21.3 Items 31200 and 31245 *do not require* the specimen to be sent for histological confirmation. Items 31205 to 31240 and 31250 *require* that the specimen be sent for histological examination. Items 31255 to 31335 *require* that the specimen be sent for histological confirmation of malignancy which *must* be received before itemisation of accounts for Medicare benefits purposes.

T8.21.4 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.

T8.21.5 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.

T8.21.6 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.

T8.21.7 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.

T8.22 Removal of Skin Lesion From Face (Items 31235-31245, 31265-31275, 31310-31320)

T8.22.1 For the purposes of these items, the face is defined as that portion of the head anterior to the hairline and above the jawline.

T8.24 Excision of Breast Lesions, Abnormalities or Tumours - malignant or benign (Items 31500 - 31515)

T8.24.1 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.

T8.27 Diagnostic Biopsy of Breast using Advanced Breast Biopsy Instrumentation (Items 31539, 31545)

T8.27.1 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.

T8.27.2 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.

T8.28 Preoperative localisation of breast lesion prior to the use of Advanced Breast Biopsy Instrumentation (Item 31542)

T8.28.1 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.

T8.29 Varicose veins, Multiple Injections of (Items 32500, 32501)

T8.29.1 Item 32500 is restricted to a maximum of six 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, the practitioner must sign and certify that the digital photograph has not been altered. 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.)

T8.29.2 In items 32500 and 32501, it is sclerosant which is being injected.

T8.29.3 Before item 32501 can be used, it is necessary to demonstrate that truncal reflux in the long or short saphenous veins does not exist on duplex examination.

T8.34 Percutaneous Transluminal Rotational Atherectomy (Items 35335, 35338, 35341, 35344)

T8.34.1 A coronary artery lesion is considered to be complex when the lesion is a chronic total occlusion, located at an ostial site, angulated, tortuous or greater than 1cm in length. Percutaneous transluminal coronary rotational atherectomy is suitable for revascularisation of complex and heavily calcified coronary artery stenoses in patients for whom coronary artery bypass graft surgery is contraindicated.

T8.34.2 Each of the items 35335, 35338, 35341 and 35344 describes an episode of service. As such, only one item in this range can be claimed in a single episode.

T8.73 Augmentation Mammaplasty (Items 45524, 45527, 45528)

T8.73.1 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 mammaplasty in association with correction of breast ptosis (items 45556, 45557 and 45558).

T8.73.2 Item 45528 applies where bilateral mammaplasty is indicated because of congenital malformation, disease or trauma of the breast (but not as a result of previous cosmetic surgery) other than covered under item 45524 or 45527. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign and certify that the digital photograph has not been altered. 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.)

T8.75 Breast Ptosis (Items 45556, 45557 and 45558)

T8.75.1 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. This item is payable only once per patient. Additional benefit is not payable if this procedure is also performed on the contralateral breast.

T8.75.2 Items 45557 and 45558 apply where correction of breast ptosis is indicated because the nipple is inferior to the infra-mammary groove. Claims for benefits should be accompanied by full clinical details including colour photographs including an anterolateral view. Where digital photographs are supplied, the practitioner must sign and certify that the digital photograph has not been altered. 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 Liposuction (Items 45584, 45585 and 45586)

T8.77.1 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.

T8.77.2 Where liposuction is indicated for the treatment of conditions such as pathological lipodystrophy of hips, buttocks, thighs and lower legs including knees (Barraquer-Simon's Syndrome), gynaecomastia or lymphoedema, item 45585 applies. Claims for benefits under this item should be accompanied by full clinical details, including pre-operative photographs of the whole body including laterals including the abdomen and breasts. Where digital photographs are supplied, the practitioner must sign and certify that the digital photograph has not been altered. 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.)

T8.77.3 Claims for benefits under item 45586 should be accompanied by full clinical details, including pre-operative colour photographs. Where digital photographs are supplied, the practitioner must sign and certify that the digital photograph has not been altered. 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.)

T8.78 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)

T8.78.1 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.

T8.78.2 Where bilateral meloplasty is indicated because of congenital malformation for conditions such as drooling from the angles of the mouth and deep pitting of the skin resulting from severe acne scarring, disease or trauma (but not as a result of previous cosmetic surgery), 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, the practitioner must sign and certify that the digital photograph has not been altered. 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.)

T8.80 Rhinoplasty (45638, 45639)

T8.80.1 Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

T8.80.2 Item 45638 applies where surgery is indicated for correction of nasal obstruction, post-traumatic deformity (but not as a result of previous elective cosmetic surgery), or both.

T8.80.3 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, the practitioner must sign and certify that the digital photograph has not been altered. 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.)

T8.85 Lumbar Discectomy (Item 48636)

T8.85.1 Following an MSAC assessment of Intradiscal Electrothermal Annuloplasty (IDETA), it was recommended that public funding not be supported for IDETA at this time therefore medical benefits are not payable for the IDETA procedure. A restriction has been placed on the item 48636 (lumbar discectomy). This item cannot be claimed for IDETA.

SUMMARY OF CHANGES - CLEFT LIP AND CLEFT PALATE SCHEDULE

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) Under the provisions of Section 3BA of the *Health Insurance Act 1973* a patient must be a prescribed dental patient, ie

- a person aged up to twenty-two years, 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*;
- a person aged up to twenty-eight years, in respect of whom, prior to turning twenty-two years,
  - 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*, and
  - that person commenced treatment for a cleft lip or cleft palate condition;
- a person aged twenty-eight and over requiring a specific course of treatment for the repair of previous reconstructive surgery, provided that:
  - prior to turning twenty-two years, 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*, and
  - the person received treatment for a cleft lip or cleft palate condition prior to turning twenty-eight years, and
  - if the Minister has declared in writing that he or she is satisfied that:
    (i) because of exceptional circumstances, the person requires repair of previous reconstructive surgery in connection with the condition, and
    (ii) the person therefore needs to undergo that course of treatment.
- A person aged up to twenty-two years 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 condition determined by the Minister to be a condition to which the definition of a prescribed dental patient under Section 3BA of the Act applies.

* 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

	GROUP A3 - SPECIALIST ATTENDANCES TO WHICH NO OTHER ITEM APPLIES
+ 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:** $57.55 **Benefit:** 75% = $43.20 85% = $48.95
	GROUP A7 - ACUPUNCTURE
197 †	Professional attendance by a general practitioner **at a place other than a hospital**, involving either: (i) 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** (ii) 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 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 *(See para A.5 and A.14 of explanatory notes to this Category)* **Fee:** $55.95 **Benefit:** 75% = $42.00 85% = $47.60
199 †	Professional attendance by a general practitioner **at a place other than a hospital**, involving either: (i) 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 a least 40 minutes; **OR** (ii) a professional attendance of at least 40 minutes duration for implementation of a management plan 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 *(See para A.5 and A.14 of explanatory notes to this Category)* **Fee:** $82.40 **Benefit:** 75% = $61.80 85% = $70.05
	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 1 - NEUROLOGY
11024 ‡	CENTRAL NERVOUS SYSTEM EVOKED RESPONSES, INVESTIGATION OF, by computerised averaging techniques, not being a service involving quantitative topographic mapping of event-related potentials and not including multifocal multichannel objective perimetry - 1 or 2 studies *(See para D1.2 and D1.5 of explanatory notes to this Category)* **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 and not including multifocal multichannel objective perimetry - 3 or more studies *(See para D1.2 and D1.5 of explanatory notes to this Category)* **Fee:** $136.95 **Benefit:** 75% = $102.75 85% = $116.45

	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 2 - OPHTHALMOLOGY
11221 ‡	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold but not including multifocal multichannel objective perimetry), 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, bilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11224 applies) ***in any 12 month period*** *(See para D1.5 of explanatory notes to this Category)* **Fee:** $54.95 **Benefit:** 75% = $41.25 85% = $46.75
11222 ‡	FULL QUANTITATIVE COMPUTERISED PERIMETRY (automated absolute static threshold but not including multifocal multichannel objective perimetry), performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, bilateral, ***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:-*** . established glaucoma (where surgery is being considered) where there has been definite progression of damage over a 12 month period; . established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or . for monitoring ocular disease caused by systemic drug toxicity, where there is also other disease such as glaucoma or neurological disease - ***each additional examination*** *(See para D1.4 and D1.5 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 but not including multifocal multichannel objective perimetry), 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, unilateral - ***to a maximum of 2 examinations*** (including examinations to which item 11221 applies) ***in any 12 month period*** *(See para D1.5 of explanatory notes to this Category)* **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15
11225 ‡	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold but not including multifocal multichannel objective perimetry), performed by or on behalf of a specialist in the practice of his or her specialty, with assessment and report, unilateral, ***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:-*** . established glaucoma (where surgery is being considered) where there has been definite progression of damage over a 12 month period; . established neurological disease which may be progressive and where a visual field is necessary for the management of the patient; or . for monitoring ocular disease caused by systemic drug toxicity, where there is also other disease such as glaucoma or neurological disease - ***each additional examination*** *(See para D1.4 and D1.5 of explanatory notes to this Category* **Fee:** $33.10 **Benefit:** 75% = $24.85 85% = $28.15

	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 5 - VASCULAR
11603 ‡	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 and not to be used in conjunction with items 32500 and 32501) - 1 examination and report *(See para D1.12 of explanatory notes to this Category)* **Fee:** $41.90 **Benefit:** 75% = $31.45 85% = $35.65
11606 ‡	- 2 examinations of the kind referred to in item 11603 and report (not being a service associated with a service to which item 11612 or 11615 applies and not to be used in conjunction with items 32500 and 32501) *(See para D1.12 of explanatory notes to this Category)* **Fee:** $59.40 **Benefit:** 75% = $44.55 85% = $50.50
11609 ‡	- 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 and not to be used in conjunction with items 32500 and 32501) *(See para D1.12 of explanatory notes to this Category)* **Fee:** $77.10 **Benefit:** 75% = $57.85 85% = $65.55
	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 11919 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, 11919, 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, 11919, 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, 11919, 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 11919, 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 11919, 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 imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11915, 11919, 11921 and 36800 apply (Anaes.) **Fee:** $347.25 **Benefit:** 75% = $260.45 85% = $295.20
* 11919	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 imaging associated with cystometrography, not being a service associated with a service to which items 11012-11027, 11900-11917, 11921 and 36800 apply (Anaes.) **Fee:** $347.25 **Benefit:** 75% = $260.45 85% = $295.20

	GROUP T2 - RADIATION ONCOLOGY
	SUBGROUP 3 - MEGAVOLTAGE
15215 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15218 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15221 †	RADIATION ONCOLOGY TREATMENT, using a single photon linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15224 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for cancers not covered by items 15215, 15218 and 15221 **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15227 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15230 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15215 plus for each field in excess of 1, an amount of $30.75
15233 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15218 plus for each field in excess of 1, an amount of $30.75
15236 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15221 plus for each field in excess of 1, an amount of $30.75
15239 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for cancers not covered by items 15230, 15233 or 15236 **Derived Fee:** The fee for item 15224 plus for each field in excess of 1, an amount of $30.75
15242 †	RADIATION ONCOLOGY TREATMENT, using a single photon energy linear accelerator with or without electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee or item 15227 plus for each field in excess of 1, an amount of $30.75

RADIATION ONCOLOGY	MEGAVOLTAGE
15245 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (lung) **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15248 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (prostate) **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15251 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site (breast) **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15254 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to primary site for cancers not covered by items 15245, 15248 or 15251 **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15257 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 1 field - treatment delivered to secondary site **Fee:** $48.40 **Benefit:** 75% = $36.30 85% = $41.15
15260 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (lung) **Derived Fee:** The fee for item 15245 plus for each field in excess of 1, an amount of $30.75
15263 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (prostate) **Derived Fee:** The fee for item 15248 plus for each field in excess of 1, an amount of $30.75
15266 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site (breast) **Derived Fee:** The fee for item 15251 plus for each field in excess of 1, an amount of $30.75
15269 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to primary site for cancers not covered by items 15260, 15263 or 15266 **Derived Fee:** The fee for item 15254 plus for each field in excess of 1, an amount of $30.75
15272 †	RADIATION ONCOLOGY TREATMENT, using a dual photon energy linear accelerator with a minimum higher energy of 10MV photons or greater, with electron facilities - each attendance at which treatment is given - 2 or more fields up to a maximum of 5 additional fields (rotational therapy being 3 fields) - treatment delivered to secondary site **Derived Fee:** The fee for item 15257 plus for each field in excess of 1, an amount of $30.75

	GROUP T3 - THERAPEUTIC NUCLEAR MEDICINE
16003 ‡	INTRACAVITARY ADMINISTRATION OF A THERAPEUTIC DOSE OF YTTRIUM 90 not including preliminary paracentesis and not being a service associated with selective internal radiation therapy (Anaes.) *(See para T8.8 of explanatory notes to this Category)* **Fee:** $527.45 **Benefit:** 75% = $395.60 85% = $470.35
	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS
18290 ‡	CRANIAL NERVE OTHER THAN TRIGEMINAL, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin (Anaes.) **Fee:** $202.50 **Benefit:** 75% = $151.90 85% = $172.15
18292 ‡	NERVE BRANCH, destruction by a neurolytic agent, not being a service associated with the injection of botulinum toxin or a service to which any other item in this Group applies (Anaes.) **Fee:** $101.20 **Benefit:** 75% = $75.90 85% = $86.05
18350 †	**BOTULINUM TOXIN** BOTULINUM TOXIN (Botox), injection of, for hemifacial spasm in adults, including all injections on any one day *(See para T7.4 of explanatory notes to this Category)* **Fee:** $101.20 **Benefit:** 75% = $75.90 85% = $86.05
18352 †	BOTULINUM TOXIN (Botox or Dysport), injection of, for cervical dystonia (spasmodic torticollis), including all injections on any one day *(See para T7.4 of explanatory notes to this Category)* **Fee:** $202.50 **Benefit:** 75% = $151.90 85% = $172.15
18354 †	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 years and 17 years inclusive, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) (Anaes.) *(See para T7.4 of explanatory notes to this Category)* **Fee:** $101.20 **Benefit:** 75% = $75.90 85% = $86.05
18356 †	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovarus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 years and 17 years inclusive, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) (Anaes.) *(See para T7.4 of explanatory notes to this Category)* **Fee:** $101.20 **Benefit:** 75% = $75.90 85% = $86.05
18358 †	BOTULINUM TOXIN (Botox or Dysport), injection of, for dynamic equinovalgus foot deformity due to spasticity in an ambulant cerebral palsy patient, between the ages of 2 years and 17 years inclusive, including all injections for all or any of the muscles subserving one functional activity, supplied by one motor nerve, with a maximum of 4 treatments per patient on any one day (2 per limb) (Anaes.) *(See para T7.4 of explanatory notes to this Category)* **Fee:** $101.20 **Benefit:** 75% = $75.90 85% = $86.05
* 18370	BOTULINUM TOXIN (Botox), injection of, for blepharospasm, including all such injections on any one day (Anaes.) *(See para T7.4 of explanatory notes to this Category)* **Fee:** $36.55 **Benefit:** 75% = $27.45 85% = $31.10

	GROUP T10 - RELATIVE VALUE GUIDE FOR ANAESTHESIA - MEDICARE BENEFITS ARE ONLY PAYABLE FOR ANAESTHESIA PERFORMED IN ASSOCIATION WITH AN ELIGIBLE SERVICE
	SUBGROUP 3 - THORAX
20440 †	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the sternum (4 basic units) **Fee:** $66.00 **Benefit:** 75% = $49.50 85% = $56.10
	SUBGROUP 9 - PELVIS (EXCEPT HIP)
21112 †	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the anterior iliac crest (4 basic units) **Fee:** $66.00 **Benefit:** 75% = $49.50 85% = $56.10
21114 †	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow biopsy of the posterior iliac crest (5 basic units) **Fee:** $82.50 **Benefit:** 75% = $61.90 85% = $70.15
21116 †	**INITIATION OF MANAGEMENT OF ANAESTHESIA** for percutaneous bone marrow harvesting from the pelvis (6 basic units) **Fee:** $99.00 **Benefit:** 75% = $74.25 85% = $84.15
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
# 30165	LIPECTOMY transverse wedge excision of abdominal apron (Anaes.) (Assist.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $368.80 **Benefit:** 75% = $276.60 85% = $313.50
# 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.) *(See para T8.12 of explanatory notes to this Category)* **Fee:** $799.20 **Benefit:** 75% = $599.40 85% = $742.10
30195 ‡	BENIGN NEOPLASM OF SKIN, 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.) **Fee:** $51.45 **Benefit:** 75% = $38.60 85% = $43.75
30196 ‡	MALIGNANT NEOPLASM 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 T8.14 of explanatory notes to this Category)* **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
30197 ‡	MALIGNANT NEOPLASM 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 T8.14 of explanatory notes to this Category)* **Fee:** $356.80 **Benefit:** 75% = $267.60 85% = $303.30
30202 ‡	MALIGNANT NEOPLASM 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 T8.14 of explanatory notes to this Category)* **Fee:** $39.15 **Benefit:** 75% = $29.40 85% = $33.30
30203 ‡	MALIGNANT NEOPLASM 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 T8.14 of explanatory notes to this Category)* **Fee:** $138.05 **Benefit:** 75% = $103.55 85% = $117.35
30205 ‡	MALIGNANT NEOPLASM OF SKIN proven by histopathology, removal of, BY LIQUID NITROGEN CRYOTHERAPY using repeat freeze-thaw cycles WHERE THE MALIGNANT NEOPLASM EXTENDS INTO CARTILAGE (Anaes.) **Fee:** $102.40 **Benefit:** 75% = $76.80 85% = $87.05
31205 ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **lesion size up to 10mm in diameter**, **removal by surgical excision and suture from cutaneous or subcutaneous tissue or from mucous membrane,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 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, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 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, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 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, ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $173.95 **Benefit:** 75% = $130.50 85% = $147.90

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
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 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $309.15 **Benefit:** 75% = $231.90 85% = $262.80
31230 ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from nose, eyelid, lip, ear, digit or genitalia,** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335 - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) (See para T8.21 *of explanatory notes to this Category)* **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85
31235 ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size up to 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $116.35 **Benefit:** 75% = $87.30 85% = $98.90
31240 ‡	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach at an operation), **removal by surgical excision and suture from face, neck (anterior to the sternomastoid muscles) or lower leg (mid calf to ankle),** ***including excision to establish the diagnosis of tumours*** covered by items 31300 to 31335, **lesion size more than 10mm in diameter** - ***where the specimen excised is sent for histological examination*** (not being a service to which item 30195 applies) (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $136.25 **Benefit:** 75% = $102.20 85% = $115.85
31250 ‡	GIANT HAIRY or COMPOUND NAEVUS, excision of an area at least 1 percent of body surface ***where the specimen excised is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $299.15 **Benefit:** 75% = $224.40 85% = $254.30
31255 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $179.50 **Benefit:** 75% = $134.65 85% = $152.60
31260 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from nose, eyelid, lip, ear, digit or genitalia, tumour size more than 10mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $255.95 **Benefit:** 75% = $192.00 85% = $217.60

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
31265 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $149.55 **Benefit:** 75% = $112.20 85% = $127.15
31270 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 10mm and up to 20mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $209.40 **Benefit:** 75% = $157.05 85% = $178.00
31275 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from face, neck (anterior to sternomastoid muscles) or lower leg (mid calf to ankle), tumour size more than 20mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $242.65 **Benefit:** 75% = $182.00 85% = $206.30
31280 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31255* and *31265*, tumour size up to 10mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $126.35 **Benefit:** 75% = $94.80 85% = $107.40
31285 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31270*, tumour size more than 10mm and up to 20mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $172.75 **Benefit:** 75% = $129.60 85% = $146.85
31290 ‡	BASAL CELL CARCINOMA OR SQUAMOUS CELL CARCINOMA (including keratocanthoma), **removal from areas of the body not covered by items *31260* and *31275*, tumour size more than 20mm in diameter** - where removal is by **surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $199.35 **Benefit:** 75% = $149.55 85% = $169.45
31295 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $237.45 **Benefit:** 75% = $178.10 85% = $201.85

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
31300 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $259.35 **Benefit:** 75% = $194.55 85% = $220.45
31305 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $319.05 **Benefit:** 75% = $239.30 85% = $271.20
31310 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $225.95 **Benefit:** 75% = $169.50 85% = $192.10
31315 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $285.80 **Benefit:** 75% = $214.35 85% = $242.95
31320 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 and T8.22 of explanatory notes to this Category)* **Fee:** $319.05 **Benefit:** 75% = $239.30 85% = $271.20
31325 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $219.40 **Benefit:** 75% = $164.55 85% = $186.50
31330 ‡	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,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $259.35 **Benefit:** 75% = $194.55 85% = $220.45

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
31335 ‡	MALIGNANT MELANOMA, APPENDAGEAL CARCINOMA, MALIGNANT FIBROUS TUMOUR OF SKIN, MERKEL CELL CARCINOMA OF SKIN or HUTCHINSON'S MELANOTIC FRECKLE - **removal from areas of the body not covered by items *31305* and *31320* - tumour size more than 20mm in diameter** - where removal is by **definitive surgical excision and suture,** ***where the specimen excised is sent for histological examination and confirmation of malignancy obtained*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $299.15 **Benefit:** 75% = $224.40 85% = $254.30
31345 ‡	LIPOMA, removal of by surgical excision or liposuction, where lesion is subcutaneous and **greater than 50mm in diameter**, or is sub-fascial, ***where the specimen is sent for histological confirmation of diagnosis*** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $170.95 **Benefit:** 75% = $128.25 85% = $145.35
31346 †	LIPOSUCTION (suction assisted lipolysis) to 1 regional area for treatment of contour problems of abdominal fat due to repeated insulin injections, ***where the lesion is subcutaneous and greater than 50mm in diameter***, not being a service to which items 45584 or 45585 apply (Anaes.) **Fee:** $170.95 **Benefit:** 75% = $128.25 85% = $145.35
31350 ‡	BENIGN TUMOUR of SOFT TISSUE, removal of by **surgical excision**, ***where the specimen excised is sent for histological confirmation of diagnosis***, not being a service to which another item in this Group applies (Anaes.) (Assist.) *(See para T8.21 of explanatory notes to this Category)* **Fee:** $351.35 **Benefit:** 75% = $263.55 85% = $298.65
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 histology (Anaes.) *(See para T8.24 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 (Anaes.) (Assist.) *(See para T8.24 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 (Anaes.) (Assist.) *(See para T8.24 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 (Anaes.) *(See para T8.24 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 (Anaes.) (Assist.) *(See para T8.24 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 (Anaes.) (Assist.) *(See para T8.24 of explanatory notes to this Category)* **Fee:** $353.60 **Benefit:** 75% = $265.20 85% = $300.60
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 31539, 31542 or 31545 applies (Anaes.) **Fee:** $153.55 **Benefit:** 75% = $115.20 85% = $130.55

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
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, 31536 or 31548 apply (Anaes.) *(See para T8.27 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 or similar device, 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 T8.28 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 or similar device, using interventional imaging techniques and including imaging not being a service to which item 31530, 31536 or 31548 apply (Anaes.) *(See para T8.27 of explanatory notes to this Category)* **Fee:** $482.95 **Benefit:** 75% = $362.25 85% = $425.85
	SUBGROUP 3 - VASCULAR
32500 ‡	**VARICOSE VEINS** VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant 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.) *(See para T8.29 of explanatory notes to this Category)* **Fee:** $89.00 **Benefit:** 75% = $66.75 85% = $75.65
32501 ‡	VARICOSE VEINS where varicosity measures 2.5mm or greater in diameter, multiple injections of sclerosant 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) and providing that truncal reflux in the long or short saphenous veins has been excluded by duplex examination ***- 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*** *(See para T8.29 of explanatory notes to this Category)* **Fee:** $89.00 **Benefit:** 75% = $66.75 85% = $75.65
35335 †	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty without stent insertion where each coronary artery lesion: - has not already been stented; and - is complex and heavily calcified and balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $717.90 **Benefit:** 75% = $538.45 85% = $660.80
35338 †	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of 1 coronary artery, including balloon angioplasty and insertion of one or more stents, where each coronary artery lesion: - has not already been stented; and - is complex and heavily calcified and balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $918.15 **Benefit:** 75% = $688.65 85% = $861.05

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 3 - VASCULAR
35341 †	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty without stent insertion where each coronary artery lesion: - has not already been stented; and - is complex and heavily calcified and balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $985.75 **Benefit:** 75% = $739.35 85% = $928.65
35344 †	PERCUTANEOUS TRANSLUMINAL ROTATIONAL ATHERECTOMY of more than 1 coronary artery, including balloon angioplasty, and insertion of one or more stents, where each coronary artery lesion: - has not already been stented; and - is complex and heavily calcified and balloon angioplasty with or without stenting is not suitable, excluding associated radiological services or preparation, and excluding aftercare (Anaes.) (Assist.) *(See para T8.34 of explanatory notes to this Category)* **Fee:** $1,286.15 **Benefit:** 75% = $964.65 85% = $1,229.05
	SUBGROUP 5 - UROLOGICAL
36836 ‡	CYSTOSCOPY, with biopsy of bladder, not being a service associated with a service to which item 36812, 36830, 36840, 36845, 36848, 36854, 37203, 37206 or 37215 applies (Anaes.) **Fee:** $186.40 **Benefit:** 75% = $139.80 85% = $158.45
36840 †	CYSTOSCOPY, with resection, diathermy or visual laser destruction of bladder tumour or other lesion of the bladder, not being a service to which item 36845 or 37224 applies (Anaes.) **Fee:** $262.05 **Benefit:** 75% = $196.55 85% = $222.75

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 5 - UROLOGICAL
37224 †	PROSTATE, diathermy or visual laser destruction of lesion of, not being a service associated with a service to which item 37201, 37202, 37203, 37206, 37207 or 37215 applies (Anaes.) **Fee:** $262.05 **Benefit:** 75% = $196.55 85% = $222.75
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 13 - PLASTIC AND RECONSTRUCTIVE SURGERY
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 congenital malformation, disease or trauma of the breast (but not as a result of previous elective cosmetic surgery)*** (Anaes.) (Assist.) *(See para T8.73 of explanatory notes to this Category)* **Fee:** $901.90 **Benefit:** 75% = $676.45 85% = $844.80
45557 ‡	BREAST PTOSIS, correction of by mastopexy (unilateral), following pregnancy and lactation, when performed after 12 months and within 7 years of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra-mammary groove (Anaes.) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $621.05 **Benefit:** 75% = $465.80 85% = $563.95
45558 ‡	BREAST PTOSIS, correction of by mastopexy (bilateral), following pregnancy and lactation, when performed after 12 months and within 7 years of the most recent pregnancy, and where it can be demonstrated that the nipple is inferior to the infra- mammary groove (Anaes.) (Assist.) *(See para T8.75 of explanatory notes to this Category)* **Fee:** $931.55 **Benefit:** 75% = $698.70 85% = $874.45
45585 ‡	LIPOSUCTION (suction assisted lipolysis) to 1 regional area, not being a service to which item 45584 or 45586 apply, ***where it can be demonstrated that the treatment is for pathological lipodystrophy of hips, buttocks, thighs and lower legs, including knees (Barraquer-Simon's Syndrome), gynaecomastia, or lymphoedema*** (Anaes.) *(See para T8.77 of explanatory notes to this Category)* **Fee:** $512.20 **Benefit:** 75% = $384.15 85% = $455.10
45586 †	LIPOSUCTION (suction assisted lipolysis) for reduction of a buffalo hump, not being a service to which items 45584 or 45585 apply, ***where it can be demonstrated that the buffalo hump is secondary to an endocrine disorder or pharmacological treatment of a medical condition*** (Anaes.) *(See para T8.77 of explanatory notes to this Category)* **Fee:** $512.20 **Benefit:** 75% = $384.15 85% = $455.10
45588 ‡	MELOPLASTY, bilateral, not being a service to which item 45587 applies, excluding browlifts and chinlift platysmaplasties, ***where it can be demonstrated that surgery is indicated because of congenital conditions, disease or trauma (but not as a result of previous elective cosmetic surgery)*** (Anaes.) (Assist.) *(See para T8.78 of explanatory notes to this Category)* **Fee:** $1,083.50 **Benefit:** 75% = $812.65 85% = $1,026.40
45638 ‡	RHINOPLASTY, TOTAL, including correction of all bony and cartilaginous elements of the external nose, for correction of nasal obstruction or post-traumatic deformity ***(but not as a result of previous elective cosmetic surgery),*** or both (Anaes.) *(See para T8.80 of explanatory notes to this Category)* **Fee:** $822.20 **Benefit:** 75% = $616.65 85% = $765.10
	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 15 - ORTHOPAEDIC
48636 ‡	PERCUTANEOUS LUMBAR DISCECTOMY, 1 or more levels not being a service associated with intradiscal electrothermal annuloplasty (Anaes.) (Assist.) *(See para T8.85 of explanatory notes to this Category)* **Fee:** $656.35 **Benefit:** 75% = $492.30 85% = $599.25

SUMMARY OF CHANGES - DIAGNOSTIC IMAGING SERVICES TABLE

The following Note DIF.2 replaces Note DIF.2 as it appears in the 1 November 2002 Medicare Benefits Schedule.

DIF.2 Benefits payable

DIF.2.1 ***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.2.2 M***usculoskeletal ultrasound of Shoulder and Knee***

Benefits for shoulder ultrasound items 55808 and 55810 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone.

Benefits for knee ultrasound items 55828 and 55830 are only payable when referral is based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee conditions including:

- meniscal and cruciate ligament tears
- assessment of chondral surfaces

DIF.7 Sonographer Accreditation (Change of Departmental contact number)
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 7315 or the Australasian Sonographer Accreditation Registry on (02) 8850 1144 or through their website at http:/www.asar.com.au

	GROUP I1 - ULTRASOUND
	SUBGROUP 6 - MUSCULOSKELETAL
55808 ‡	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 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, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95
55810 ‡	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific shoulder pain alone*. SHOULDER OR UPPER ARM, 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, and where the service is provided, for the assessment of one or more of the following conditions or suspected conditions: - evaluation of injury to tendon, muscle or muscle/tendon junction; or - rotator cuff tear/calcification/tendinosis (biceps, subscapular, supraspinatus, infraspinatus); or - biceps subluxation; or - capsulitis and bursitis; or - evaluation of mass including ganglion; or - occult fracture; or - acromioclavicular joint pathology.(NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50
55828 ‡	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 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, and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(R) **Fee:** $99.90 **Benefit:** 75% = $74.95 85% = $84.95

	GROUP I1 - ULTRASOUND
	SUBGROUP 6 - MUSCULOSKELETAL
55830 ‡	Note: *Benefits are only payable when referred based on the clinical indicators outlined in the item descriptions. Benefits are not payable when referred for non-specific knee pain alone or other knee condition including:* - meniscal and cruciate ligament tears - assessment of chondral surfaces KNEE, 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 and where the service is provided for the assessment of one or more of the following conditions or suspected conditions: - abnormality of tendons or bursae about the knee; or - meniscal cyst, popliteal fossa cyst, mass or pseudomass; or - nerve entrapment, nerve or nerve sheath tumour; or - injury of collateral ligaments.(NR) **Fee:** $34.65 **Benefit:** 75% = $26.00 85% = $29.50

SUMMARY OF CHANGES - PATHOLOGY SERVICES TABLE

The items used to detect foetal abnormality have been restructured by deleting items 66740 and 66746, amending item 66743 and creating two new items 66750 and 66751. This restructure allows for testing in both first and second trimesters.

There has been a restructure of the faeces items resulting in the deletion of items 69342, 69348 and 69351 and amendments to items 69336, 69339, 69345 and 69363.

Following the Minister's recommendation of public funding for Fragile X (A) Syndrome testing, items 73287 and 73289 have been amended and two new items - 73300 and 73305 - have been introduced. These new items are complemented by a new explanatory note (see Note PP.12 below).

Item 69318 has been amended to clarify any ambiguity by making it quite clear that any specimen from any site is included.

Item 66650 has been amended to include the conditions where these tests would be appropriate for detection as well as monitoring.

Carboxyhaemoglobin item 65117 has been amended to remove the reference to qualitative.

The reference to item 69484 has been removed from items 69405, 69408 and 69411 to allow for confirmatory testing of hepatitis C during pregnancy.

The following sub-rules have been amended to remove anomalies created by changes made in November 2002:

13.(4) If more than 1 of the services mentioned in items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 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.(6) In items 72813, 72816, 72817, 72818, 72823, 72824, 72825, 72826, 72830 and 72836 a reference to a ***complexity level*** is a reference to the level given to a specimen type mentioned in Part 5 of this Table.

The group of tests described in PQ.4 under coagulation studies has been expanded to include full blood count and item 65070 - as noted below.

PQ.4 Groups of Tests

Group	***Estimations Included in Group***	***Group Abbreviation***	***Item Numbers***
Coagulation studies	*Full blood count, Prothrombin time, activated partial thrombo- plastin 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* *65070*

The following explanatory note has been amended to incorporate the pathologist-determinable services as determined by the Minister of Health and Ageing -

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:

(a) that is rendered by or on behalf of an Approved Pathology Provider for a person who is a patient of that Approved Pathology Provider who has determined that the service is necessary; or

(b) is a service specified in only one of items 72846 or 72847 or items 73059 or 73060; and is consider necessary by the Approved Pathology Provider as a consequence of information resulting from a pathology service contained in items 72813 - 72836 or items 73045 - 73051, respectively.

Please note: a written request is required for a service contained in items 72813 to 72836 and items 73045 to 73051.

Further information on additional pathology tests not covered by a request is provided at PB.3.

The following is a new explanatory note:

PP.12 - Fragile X (A) Tests (Items 73300 and 73305)
Prior to ordering these tests (73300 and 73305) the ordering practitioner should ensure the patient has given informed consent. Appropriate genetic counselling should be provided to the patient either by the treating practitioner, a genetic counselling service or by a clinical geneticist on referral. Further counselling may be necessary upon receipt of the test results.

	GROUP P1 - HAEMATOLOGY
65117 ‡	1 or more of the following tests: (a) Spectroscopic examination of blood for chemically altered haemoglobins; (b) detection of methaemalbumin (Schumm's test) **Fee:** $20.00 **Benefit:** 75% = $15.00 85% = $17.00
	GROUP P2 - CHEMICAL
66650 ‡	Alpha-fetoprotein, CA-15.3 antigen (CA15.3), CA-125 antigen (CA125), CA-19.9 antigen (CA19.9), cancer associated serum antigen (CASA), carcinoembryonic antigen (CEA), human chorionic gonadotrophin (HCG), mammary serum antigen (MSA), thyroglobulin in serum or other body fluid, in the monitoring of malignancy or in the detection or monitoring of hepatic tumours, gestational trophoblastic disease or germ cell tumour - quantitation - 1 test **Fee:** $24.00 **Benefit:** 75% = $18.00 85% = $20.40
66743 ‡	Quantitation of alpha-fetoprotein in serum or other body fluids during pregnancy except if requested as part of items 66750 or 66751 **Fee:** $19.90 **Benefit:** 75% = $14.95 85% = $16.95
66750 †	Quantitation, in pregnancy, of any two of the following - total human chorionic gonadotrophin (total HCG), free alpha human chorionic gonadotrophin (free alpha HCG), free beta human chorionic gonadotrophin (free beta HCG), pregnancy associated plasma protein A (PAPP-A), unconjugated oestriol (uE_3), alpha-fetoprotein (AFP) - to detect foetal abnormality, including a service described in 1 or more of items 73527 and 73529 (if performed) - 1 patient episode in a pregnancy **Fee:** $39.25 **Benefit:** 75% = $29.45 85% = $33.40
66751 †	Quantitation, in pregnancy, of any three or more test described in 66750 **Fee:** $54.50 **Benefit:** 75% = $40.90 85% = $46.35
	GROUP P3 - MICROBIOLOGY
+ 69315	Microscopy and culture to detect pathogenic micro-organisms, and the detection of chlamydia from urethra, vagina, cervix or rectum and including (if performed): (a) the detection of microbial antigens; or (b) pathogen identification and antibiotic susceptibility testing; or (c) a service described in items 69300, 69303, 69306, 69312, 69318, 69363, 69369, 69370, 69372, 69375 or 73810; 1 or more tests on 1 or more specimens **Fee:** $60.80 **Benefit:** 75% = $45.60 85% = $51.70
69318 ‡	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): (a) the detection of antigens (from any type of specimen) not elsewhere specified in this Table, including item 69372; or (b) pathogen identification and antibiotic susceptibility testing; or (c) a service described in items 69300, 69303, 69306 and 69312; 1 or more tests on 1 or more specimens **Fee:** $33.00 **Benefit:** 75% = $24.75 85% = $28.05
+‡ 69336	Microscopy of faeces for ova, cysts and parasites using concentration techniques and including use of fixed stains for cryptosporidia and giardia - 1 examination in any 7 day period **Fee:** $30.65 **Benefit:** 75% = $23.00 85% = $26.10
+‡ 69339	Microscopy of faeces for ova, cysts and parasites using concentration techniques examined subsequent to item 69336 on a separately collected and identified specimen collected within 7 days of the examination described in 69336 - 1 examination in any 7 day period **Fee:** $18.65 **Benefit:** 75% = $14.00 85% = $15.90
69345 ‡	Culture and (if performed) microscopy without concentration techniques of faeces for faecal pathogens, using at least 2 selective or enrichment media and culture in at least 2 different atmospheres including (if performed): (a) pathogen identification and antibiotic susceptibility testing; and (b) the detection of clostridial toxins; and (c) a service described in item 69300; - 1 examination in any 7 day period **Fee:** $51.65 **Benefit:** 75% = $38.75 85% = $43.95
69363 ‡	Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in item 69345, 69369, 69370 or 69372 has been performed) - 1 or more tests **Fee:** $25.00 **Benefit:** 75% = $18.75 85% = $21.25

69405 ‡	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: (a) the determination of 1 of the following - rubella immune status, specific syphilis serology, or carriage of Hepatitis B; and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478, 69481, 69487, 69490 and 69493 **Fee:** $15.30 **Benefit:** 75% = $11.50 85% = $13.05
69408 ‡	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: (a) the determination of 2 of the following - rubella immune status, specific syphilis serology, or carriage of Hepatitis B; and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478, 69481, 69487, 69490 and 69493 **Fee:** $27.15 **Benefit:** 75% = $20.40 85% = $23.10
69411 ‡	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: (a) the determination of all 3 of the following - rubella immune status, specific syphilis serology, and carriage of Hepatitis B; and (b) (if performed) a service described in 1 or more of items 69384, 69475, 69478, 69481, 69487, 69490 and 69493 **Fee:** $38.15 **Benefit:** 75% = $28.65 85% = $32.45
	GROUP P7 - CYTOGENETICS
73287 ‡	Chromosome studies, including preparation, count, karyotyping and identification by banding techniques 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 of blood - 1 or more tests **Fee:** $322.00 **Benefit:** 75% = $241.50 85% = $273.70
73300 †	Detection of genetic mutation of the FMR1 gene by nucleic acid amplification (NAA) where: (a) the patient exhibits the specific clinical features of fragile X (A) syndrome, including intellectual disabilities; or (b) the patient has a first or second degree relative with a fragile X (A) mutation 1 or more tests *(See para PP.12 of explanatory notes to this Category)* **Fee:** $100.00 **Benefit:** 75% = $75.00 85% = $85.00
73305 †	Detection of genetic mutation of the FMR1 gene by Southern Blot where the results in item 73300 are inconclusive *(See para PP.12 of explanatory notes to this Category)* **Fee:** $200.00 **Benefit:** 75% = $150.00 85% = $170.00