The Australian Government
Department of Health and Ageing

Supplement to the

Medicare Benefits Schedule

Of 1 November 2003

Effective 1 May 2004

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The arrangements contained in this book operate under the *Health Insurance Act 1973* (as amended). However, at the time of printing, the relevant legislation giving authority for the changes included in this edition of the book may still be subject to the approval of Executive Council and the usual Parliamentary scrutiny. This book is not a legal document, and, in cases of discrepancy, the legislation will be the source document for payment of Medicare benefits.

SUPPLEMENT TO 1 NOVEMBER 2003 MEDICARE BENEFITS SCHEDULE

AMENDMENTS EFFECTIVE 1 MAY 2004

This supplement provides details of changes to the 1 November 2003 edition of the Medicare Benefits Schedule. Any item not included in this supplement remains as it is shown in the 1 November 2003 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.

MEDICARE PLUS SAFETY NET

Medicare will now meet 80% of the out-of-pocket costs (ie the difference between the fees charged and the Medicare benefits paid) for out-of-hospital medical services, once an annual threshold of $300 for families in receipt of the Family Tax Benefit (A) and concession card holders, or $700 for all other individuals and families is reached.

Individual and family safety net thresholds are calculated and monitored by the Health Insurance Commission. Individuals are automatically registered with Medicare for the safety net threshold and families are required to register with Medicare to be eligible.

Safety net thresholds include out-of-pocket expenses for all out-of-hospital services accrued from 1 January 2004. Once an individual or family has reached the relevant threshold any claim lodged after 12 March 2004 will be paid at the higher rate.

The existing Medicare Benefits safety net will continue to operate in conjunction with the Medicare Plus safety net.

AMENDMENTS TO GENERAL MEDICAL SERVICES

The changes involve the following areas of the Schedule:-

- **Aboriginal and Torres Strait Islander adult health check -** A new item (710) and new Note A36 have been introduced for a two-yearly health check for Aboriginal and Torres Strait Islander people aged a least 15 years old and less than 55 years old. The health check includes taking the patient's history, examining the patient, undertaking or arranging any required investigations, assessing the patient, making or arranging any necessary interventions or referrals, and documenting a straightforward strategy for good health.
- **Ophthalmology** - Items 11221 to 11243 and the associated explanatory notes have been corrected to reflect how this range of items were intended to be published in the 1 November 2003 MBS.
- **Phonocardiography -** Item 11706 has been deleted.
- **Capsule endoscopy** - Following a recommendation of the Medical Services Advisory Committee item 11820 has been introduced to investigate episodes of obscure gastrointestinal bleeding. New note D1.21 explains the circumstances under which the item can be claimed.
- **Thyrotropin alfa-rch** - Following a recommendation of the Medical Services Advisory Committee item 12201 has been introduced for the detection of recurrent well-differentiated thyroid cancer in patients for whom thyroid hormone therapy withdrawal is medically contra-indicated. New note D1.23 explains the circumstances under which the item can be claimed.
- **Regional or Field Nerve Blocks -** Note T7.6 has been added to better clarify the use of items 18234 to 18288.
- **General Surgery** - Item 30096 and the associated note T8.11 has been amended to ensure good clinical practice by defining the method of biopsy as an open procedure and requiring the biopsy specimen to be sent for pathological examination.
  - Item 31200 has been amended to exclude shave excision as a method of removal for tumours, cysts, ulcers and scars, to reflect the original intent of the item, and to clarify billing practices for this item.
  - Item 31340 has been amended to align this item with other items it can be claimed in conjunction with, in that there will be a requirement for the excised specimen to be sent for histological examination.
- **Palmar or Plantar Warts** - Note T8.13.3 has been amended to clarify that the full fee for item 30186 applies to the removal of the first wart and that progressively reducing levels of fees apply to each wart thereafter (Note T8.5 refers), up to a total of nine warts. This is in contrast to item 30185 where a flat fee is payable for the removal of 10 or more warts.
- **Colorectal Surgery** - Following a recommendation of the Medical Services Advisory Committee items 32103, 32104 and 32106 have been introduced for the removal of rectal tumours by transanal endoscopic microsurgery for tumours that cannot be removed during colonoscopy or by local excision. The anterior resection items, 32024 and 32025 have been amended to exclude their use in conjunction with the transanal endoscopic microsurgery items. New note T8.29 explains the circumstances under which the item can be claimed and Note T8.18 explains appropriate minimum standards for the performance of gastrointestinal endoscopy.

- Items 32159 and 32162 have been amended to include the insertion of a Seton suture. These items can now be claimed if an excision, insertion of a Seton or a combination of both procedures are performed on the lower or upper half of the anal sphincter.

- **Tunnelled Cuffed Catheter -** Two new items 34538 and 34539 have been introduced. One for the insertion of a tunnelled cuffed catheter in the central vein, by percutaneous technique, to administer haemodialysis and parenteral nutrition and the other for the removal of tunnelled cuffed catheters by open surgical technique.
- **Peripheral Arterial or Venous Embolisation -** Item 35321 has been amended and new note T8.35 has been added to clarify that benefits for uterine artery embolisation for the treatment of uterine fibroids cannot be claimed under this or any other item.
- **Prolapse and Stress Incontinence Gynaecological Surgery -** Items 35576-35584, 35590-35593, 35599-35605 and 37042-37044 have been amended to clarify that the use of mesh is covered under these items and to ensure that only these are claimed when mesh is used in these procedures.
- **Urology -** Items 36526 and 36527 and new note T8.44 have been introduced for the removal of kidney tumours that are clinically suspected to be malignant, but confirmation by biopsy prior to surgery by radical nephrectomy, cannot be obtained.
  - Item 36564 has been amended and an explanatory note introduced to reflect good clinical practice by defining the surgery performed as either by open procedure, or by laparoscopic approach.
- **Thoracic Surgery** - Item 38436 has been amended to reflect current practice in that during thoracoscopy it is not always necessary to insert an intercostal catheter.
- **Plastic Surgery** - Amendments to explanatory note T8.74.1 (as it appeared in the 1 November 2003 MBS Book) have been made to clarify that benefits are not payable for breast ptosis items 45556, 45557 and 45558 in association with augmentation mammaplasty, when both procedures are performed on the same side.
  - Amendments to explanatory notes T8.15, T8.29, T8.68, T8.74, T8.76, T8.78, T8.79, T8.81 and T8.90 (as they appeared in the 1 November 2003 MBS Book) have been made to clarify that digital photographs submitted for evaluation to the Medicare Claims Review Panel, must have the practitioner's signature on each photograph for certification of authenticity.
- **Neurosurgery** - Item 40905 has been introduced for craniotomy performed in association with items 45767, 45776, 45782 and 45785 for craniofacial abnormalities.
- **Radiofrequency ablation** - Following a recommendation of the Medical Services Advisory Committee items 50950 and 50952 have been introduced for the destruction of non-resectable primary liver tumours. New note T8.94 explains the circumstances under which the item can be claimed. The hepatic cryotherapy for destruction of liver tumours item, 30419 has been amended to exclude its use in conjunction with the radiofrequency ablation items.

A.36 Aboriginal and Torres Strait Islander Adult Health Check (Item 710)

The purpose of this adult health check is to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

This item applies to an Aboriginal and/or Torres Strait Islander person who is at least 15 years old and less than 55 years old. It complements the existing voluntary annual health assessment, available to Aboriginal and Torres Strait Islander people aged 55 years and over.

The major causes of excess mortality in this population are:

- circulatory conditions (including ischaemic heart disease, hypertension, cerebrovascular disease and rheumatic heart disease);
- external causes (including accidents, injury to self and others, and the sequelae of substance use);
- respiratory conditions (related to infection and to tobacco use); and
- endocrine causes (mainly type two diabetes and its complications).

Cervical cancer remains a significant cause of death in this under-screened population.

Causes of morbidity vary but include the risk factors and precursors of all the above. They also include infections of the respiratory system, the ears (in particular, Chronic Suppurative Otitis Media), the eyes (trachoma in some settings) the skin and the gastrointestinal system. End-stage renal disease is a major cause of hospitalisations, and much early renal disease remains undetected. In some settings, sexually transmissible infections are particularly common.

Living environments may be compromised by one or more of the following - overcrowding, limited access to clean water and sanitation, and poverty. In addition to the usual spectrum of mental disorder, social and family life may be negatively influenced by an excessive burden of care for family members, by substance use and sometimes by family violence.

A.36.1 An Aboriginal and Torres Strait Islander Adult Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and whether preventive health care, education

and other assistance should be offered to that patient, to improve the patient's health and physical, psychological or social function.

A.36.2 This item does not apply to people who are in-patients of a hospital, day hospital facility or care recipients in a residential aged care facility. Practitioners should consider the applicability of other medical services, including other Enhanced Primary Care services, to ensure that the health needs of eligible patients as identified in the health check are followed up.

A.36.3 For the purposes of this item a person is an Aboriginal and/or Torres Strait Islander person if the person identifies himself or herself as being of Aboriginal and/or Torres Strait Islander descent. Patients should be asked to self-identify their Aboriginal and/or Torres Strait Islander status and their age for the purpose of these items, either verbally or by completing a form.

A.36.4 The Aboriginal and Torres Strait Islander adult health check should generally be undertaken by the patient's 'usual doctor', that is the medical practitioner, or a practitioner working in the medical practice or health service, who has provided the majority of services to the patient in the past twelve months, or who will provide the majority of services in the following twelve months.

Before the health check is commenced, the patient must be given an explanation of the health check process and its likely benefits, and must be asked by the medical practitioner whether they consent to the health check being performed. Consent must be noted on the patient record.

When a medical practitioner undertakes a health check for an Aboriginal and/or Torres Strait Islander person, he or she should consider the results of any previous consultations and health checks for that person. It may therefore be appropriate to obtain and consider the patient's relevant medical records, where these are available, before undertaking the health check.

A.36.5 The information collection component of the assessment may be completed by an Aboriginal/Torres Strait Islander health worker, nurse or other qualified health professional where:

(a) the patient's medical practitioner has initiated the collection of information by a third party, after the patient has agreed to the Adult Health Check and has agreed to a third party collecting information for the assessment;
(b) the patient is told whether or not information collected about them for the health check will be retained by the third party; and
(c) the third party acts under the supervision of the practitioner.

The other components of the health check must include a personal attendance by the medical practitioner.

A.36.6 The medical practitioner should:

(a) be satisfied that the person collecting information for the Adult Health Check has the necessary skills, expertise, training and cultural awareness;
(b) have established how the information is to be collected and recorded (including any forms used);
(c) set or approve the quality assurance procedures for the information collection;
(d) be consulted on any issues arising during the information collection; and
(e) review and analyse the information collected to prepare the report of the health check and communicate to the patient their recommendations about matters covered by the health check.

A.36.7 An Aboriginal and Torres Strait Islander Adult Health Check must include:

(a) taking the patient's medical history;
(b) examining the patient;
(c) undertaking or arranging any required investigation;
(d) assessing the patient using the information gained in the health check; and
(e) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

A.36.8 HISTORY

The health check must include the taking of a comprehensive patient medical history (if one does not already exist) or the updating of that history (if it already exists). This should include recording personal information relating to the patient - name, age and gender. It is also recommended that contact details are updated at each appointment and that alternative contact details for the patient are recorded.

Mandatory matters:

(a) medical history, current health problems and health risk factors;
(b) relevant family medical history;
(c) medication usage - including OTC and medication from other doctors;

(d) immunisation status (refer to the appropriate current age and sex immunisation schedule);
(e) sexual and reproductive health;
(f) physical activity, nutrition and alcohol, tobacco or other substance use;
(g) hearing loss;
(h) mood (depression and self-harm risk); and
(i) family relationships and whether the patient is a carer or is cared for by another person.

Optional, as indicated for the patient:
(a) visual acuity (recommended for people over 40);
(b) work status (eg paid/unpaid work, Community Development Employment Projects, in training or education);
(c) environmental and living conditions;
(d) other history as considered necessary by the practitioner/collector.

A.36.9 EXAMINATION

Mandatory matters:
(a) measurement of the patient's blood pressure, pulse rate and rhythm;
(b) measurement of height and weight to calculate BMI, and, if indicated, measurement of waist circumference for central obesity;
(c) oral examination (gums and dentition);
(d) ear and hearing (otoscopy and, if indicated, a whisper test); and
(e) urinalysis (dipstick) for proteinurea.

Optional, as indicated for the patient:
(a) reproductive and sexual health examination;
(b) trichiasis check where indicated;
(c) skin examination;
(d) visual acuity (recommended for all aged over 40); and
(e) other examinations considered necessary by the practitioner.

A.36.10 INVESTIGATIONS AS REQUIRED

Arrange or undertake investigations as clinically indicated, considering the need for the following tests, in particular, in accordance with national or regional guidelines or specific regional needs:

(a) fasting blood sugar and lipids (laboratory based test on venous sample) but random blood glucose levels if necessary;
(b) pap smear;
(c) STI testing (urine or endocervical swab for chlamydia/gonorrhoea, especially for those aged 15-35 years);
(d) mammography, where eligible (by scheduling appointments with visiting services or facilitating direct referral); and
(e) other investigations considered necessary by the practitioner, in accordance with current recommended guidelines.

Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

A.36.11 ASSESSMENT OF PATIENT

The overall assessment of the patient, including the patient's level of cardiovascular risk, must be based on consideration of evidence from patient history, examination and results of any investigations. Note that if tests have been ordered but results are not yet available, the practitioner may choose to either complete the health check and review the test results as opportunity arises in a subsequent consultation, or defer completion of the health check until the results are available. In either case the practitioner should ensure that any test results are reviewed and followed up as necessary.

A.36.12 INTERVENTION

As part of the health check the practitioner must initiate intervention activity which he or she considers necessary to meet the identified needs of the patient.

The practitioner must assess risk factors and should discuss those risk factors with the patient. The practitioner should provide or arrange for preventive health advice and intervention activity as indicated (including arranging for activity and services by other local health and care providers). This may include:
- initiation of treatment, referral and/or immunisation;
- education, advice and/or assistance in relation to smoking, nutrition, alcohol / other substance use, physical activity

(SNAP), reproductive health issues eg pre-pregnancy education/ counselling, safer sex and/or social and family issues; and

– other interventions considered necessary by the practitioner.

The practitioner must develop a simple strategy for good health for the patient, including identification of required services and actions the patient should take, based on information from the health check. It should take account of any relevant previous advice given to the patient and the outcome of that advice. The strategy for good health should be developed in collaboration with the patient and must be documented in the report about the health check.

A.36.13 The health check must also include keeping a record of the health check, and offering the patient a written report about the health check, with recommendations about matters covered by the health check, including a simple strategy for the good health of the patient.

In circumstances where the patient's usual practitioner or practice has not undertaken the health check, a copy of the health check report should be forwarded to that medical practitioner or practice, with the patient's consent.

A.36.14 It is recommended that practitioners establish a register of their patients seeking a two yearly health check and remind registered patients when their next health check is due.

D1.21 Capsule Endoscopy to investigate obscure gastrointestinal bleeding (Item 11820)

D1.21.1 Capsule endoscopy is primarily used to view the small bowel, which cannot be viewed by upper gastrointestinal endoscopy and colonoscopy. Item 11820 is limited to patients with obscure gastrointestinal bleeding, the diagnosis of which can only be established when the cause of bleeding has not been identified by upper gastrointestinal endoscopy and colonoscopy. The item is limited to patients who have a history of gastrointestinal bleeding, and cannot be used for patients who are presenting with their first bleeding episode.

D1.21.2 For benefits to be payable under this item, capsule endoscopy must be provided within 6 months of the prerequisite upper gastrointestinal endoscopy and colonoscopy. Any bleeding after that time is considered to be a new episode. It is not expected that capsule endoscopy would be provided more than once in an episode of bleeding, or provided to the same patient on more than two occasions in a twelve month period.

D2.21.3 The Conjoint Committee comprises representatives from the Gastroenterological Society of Australia (GESA), the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS). For the purposes of Item 11820, specialists or consultant physicians performing this procedure must have endoscopic training recognised by the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, and the Health Insurance Commission must be notified of that recognition.

D1.21.4 The item was introduced into the Schedule on an interim basis following a recommendation of the Medical Services Advisory Committee (MSAC). Interim funding until 30 April 2007 is being provided to facilitate collection of Australian evidence of the long term safety, effectiveness, and cost-effectiveness of this procedure. Data collection and analysis is being conducted by GESA. Continuation of funding is dependent on the progress of this data collection. Therefore providers of this service are strongly encouraged to take part in the data collection process. Further information on the data collection process is available from GESA.

D1.23 Administration of thyrotropin alfa-rch for the detection of recurrent well-differentiated thyroid cancer (item 12201)

D1.23.1 Thyrotropin alfa-rch is a diagnostic agent that allows patients to remain on thyroid hormone therapy while being assessed for recurrent cancer. This item was introduced following an assessment by the Medical Services Advisory Committee (MSAC) of the available evidence relating to the safety, effectiveness and cost-effectiveness of thyrotropin alfa- rch. MSAC found that the use of thyrotropin alfa-rch is associated with a lower diagnostic accuracy than when the patient has withdrawn from thyroid hormone therapy. Accordingly, benefits are payable under the item only for patients in whom thyroid hormone therapy withdrawal is medically contraindicated and where concurrent whole body study using radioactive iodine and serum thyroglobulin are undertaken. Services provided to patients who do not demonstrate the indications set out in item 12201 do not attract benefits under the item.

D1.23.2 "Severe psychiatric illness" is defined as patients with a severe pre-existing psychiatric illness who are currently under specialist psychiatric care.

D1.23.3 The item includes the cost of supplying thyrotropin alfa-rch and the equivalent of a subsequent specialist attendance. "Administration" means an attendance by the specialist or consultant physician (the administering practitioner) that includes:

- an assessment that the patient meets the criteria prescribed by the item;
- the supply of thyrotropin alfa-rch;
- ensuring that thyrotropin alfa-rch is injected (either by the administering practitioner or by another practitioner) in two doses at 24 hour intervals, with the second dose being administered 48 hours prior to whole body study with radioactive iodine and serum thyroglobulin test; and

- arranging the whole body radioactive iodine study and the serum thyroglobulin test.

D1.23.4 Where thyrotropin alfa-rch is injected by the administering practitioner, benefits are not payable for an attendance on the day the second dose is administered. Where thyrotropin alfa-rch is injected by: a general practitioner - benefits are payable under a Level A consultation (item 3); other practitioners - benefits are payable under item 52.

T7.6 Regional or Field Nerve Blocks (Items 18234 - 18288)

T7.6.1 Items in the range 18234 - 18288 are intended to cover the injection of anaesthetic into the nerve or nerve sheath and not for the treatment of carpel tunnel or similar compression syndromes.

T8.11 Biopsy for Diagnostic Purposes (Items 30071-30096)

T8.11.1 Needle aspiration biopsy attracts benefits on an attendance basis and not under item 30078.

T8.11.2 Item 30071 should be used when a biopsy of a lesion is required to confirm a diagnosis and would facilitate the appropriate management of that lesion.

T811.3 Items 30071-30096 require that the excised specimen be sent for pathological examination.

T8.13 Treatment of Keratoses, Warts etc (Items 30185, 30186, 30187, 30189, 30192, 36815)

T8.13.1 Treatment of seborrheic keratoses by any means, attracts benefits on an attendance basis only.

T8.13.2 Treatment of less than 10 solar keratoses by ablative techniques such as cryotherapy attracts benefits on an attendance basis only. Where 10 or more solar keratoses are treated by ablative techniques, benefits are payable under item 30192. Where one or more solar keratoses are treated by electrosurgical destruction, simple curettage or shave excision, benefits are payable under item 30195.

T8.13.3 Warts and molluscum contagiosum where treated by any means attract benefits on an attendance basis except where:

a) admission for treatment in an operating theatre of an accredited day surgery facility or hospital is required. In this circumstance, benefits are paid under item 30189 where a definitive removal of the wart or molluscum contagiosum is to be undertaken.

b) benefits have been paid under item 30189, and recurrence occurs.

c) definitive removal of palmar or plantar warts is undertaken. In these circumstances, where less than 10 palmar or plantar warts are treated, by methods other than ablative techniques alone, benefits are paid under item 30186, with fees progressively reducing as for multi operations, and where 10 or more palmar or plantar warts are treated, by methods other than ablative techniques alone, benefits are paid as a flat fee under item 30185.

d) palmar and plantar warts are treated by laser and require treatment in an operating theatre of an accredited day surgery facility or hospital. In this circumstance, benefits are paid under item 30187.

T8.13.4 Ablative techniques include cryotherapy and chemical removal.

T8.15 Telangiectases or Starburst Vessels (Items 30213, 30214)

T8.15.1 These items are restricted to treatment on the head and/or neck. A session of less than 20 minutes duration attracts benefits on an attendance basis.

T8.15.2 Item 30213 is restricted to a maximum of 6 sessions in a 12 month period. Where additional treatments are indicated in that period, item 30214 should be used. Claims for benefits under item 30214 should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to 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.)

T8.18 Gastrointestinal endoscopic procedures (Items 30473-30481, 30484-30487, 30490-30494, 32084-32095, 32103, 32104 and 32106)

T8.18.1 The following are guidelines for appropriate minimum standards for the performance of GI endoscopy in relation to (a) cleaning, disinfection and sterilisation procedures, and (b) anaesthetic and resuscitation equipment. These guidelines are based on the advice of the Gastroenterological Society of Australia, the Sections of HPB and Upper GI and of Colon and Rectal Surgery of the Royal Australasian College of Surgeons, and the Colorectal Surgical Society of Australia.

Cleaning, disinfection and sterilisation procedures

T8.18.2 Endoscopic procedures should be performed in facilities where endoscope and accessory reprocessing protocols follow procedures outlined in:-

(i) 'Infection and Endoscopy' (3rd edition), Gastroenterological Society of Australia;

(ii) 'Infection control in the health care setting - Guidelines for the prevention of transmission of infectious diseases', National Health and Medical Research Council; and

(iii) Australian Standard AS 4187-1994 (and Amendments), Standards Association of Australia.

Anaesthetic and resuscitation equipment

T8.18.3 Where the patient is anaesthetised, anaesthetic equipment, administration and monitoring, and post operative and resuscitation facilities should conform to the standards outlined in 'Sedation for Endoscopy', Australian & New Zealand

College of Anaesthetists, Gastroenterological Society of Australia and Royal Australasian College of Surgeons.
T8.18.4 These guidelines will be taken into account in determining appropriate practice in the context of the Professional Services Review process (see paragraph 8.1 of the General Notes for Guidance).

T8.29 Per anal excision of rectal tumour using stereoscopic rectoscopy (Items 32103, 32104 and 32106)
T8.29.1 For the purposes of items 32103, 32104 and 32106, surgeons performing this procedure should be colorectal surgeons and have evidence of the appropriate training recognised by the Colorectal Surgical Society of Australasia.
T8.29.2 Items 32103, 32104 or 32106 cannot be claimed in conjunction with each other or with anterior resection items 32024 or 32025 for the same patient, on the same day, by any practitioner.

T8.30 (Formerly Note T8.29 in 1 November 2003 MBS)
T8.30 Varicose veins, Multiple Injections of (Items 32500, 32501)
T8.30.1 Item 32500 is restricted to a maximum of 6 treatments in a 12 month period. Where additional treatments are necessary in that period, item 32501 applies. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to 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.)
T8.30.2 In items 32500 and 32501, it is sclerosant which is being injected.
T8.30.3 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.

T8.35 Peripheral Arterial or Venous Embolisation (Item 35321)
T8.35.1 Uterine artery embolisation for the treatment of uterine fibroids cannot be claimed under this or any other item. This is a new medical procedure which requires assessment by the Medical Services Advisory Committee (MSAC) to determine whether it should be supported for listing on the MBS. (Further information is available from the MSAC Secretariat (see para 8.4 of the General Explanatory Notes).

T8.44 Nephrectomy (Items 36526 and 36527)
T8.44.1 Items 36526 and 36527 are only claimable where the practitioner has a high index of suspicion of malignancy which cannot be confirmed by biopsy prior to surgery being performed, due to the biopsy being either clinically inappropriate, or the specimen provided showing an inconclusive diagnosis.

T8.71 (Formerly Note T8.68 in 1 November 2003 MBS)
T8.71 Full Face Chemical Peel (Items 45019, 45020)
T8.71.1 These items relate to full face chemical peel in the circumstances outlined in the item descriptors. Claims for benefits should be accompanied by full clinical details, including pre-operative colour photographs, to confirm that the conditions for payment of benefits have been met. Where digital photographs are supplied, the practitioner must sign each photograph to 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 (Formerly Note T8.74 in 1 November 2003 MBS)
T8.77 Augmentation Mammaplasty (Items 45524, 45527, 45528)
T8.77.1 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 breast ptosis (items 45556, 45557 and 45558) in association with augmentation mammaplasty when both procedures are performed on the same side.
T8.77.2 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 each photograph to 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.)

T8.79 (Formerly Note T8.76 in 1 November 2003 MBS)
T8.79 Breast Ptosis (Items 45556, 45557 and 45558)
T8.79.1 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.
T8.79.2 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 anterorlateral view. Where digital photographs are supplied, the practitioner must sign each photograph to 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.)

T8.81 (Formerly Note T8.78 in 1 November 2003 MBS)

T8.81 Liposuction (Items 45584, 45585 and 45586)

T8.81.1 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.

T8.81.2 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 each photograph to 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.)

T8.81.3 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 each photograph to 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.)

T8.82 (Formerly Note T8.79 in 1 November 2003 MBS)

T8.82 Meloplasty for Correction of Facial Asymmetry (Items 45587, 45588)

T8.82.1 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.

T8.82.2 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 each photograph to 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.)

T8.82.3 For the purpose of items 45587 and 45588 severe acne scarring is defined as scarring on the face or cheeks that is obvious from a distance of 2 metres.

T8.84 (Formerly Note T8.81 in 1 November 2003 MBS)

T8.84 Rhinoplasty (45638, 45639)

T8.84.1 Benefits are payable for septoplasty (item 41671) where performed in conjunction with rhinoplasty.

T8.84.2 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.

T8.84.3 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 each photograph to 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.)

T8.93 (Formerly Note T8.90 in 1 November 2003 MBS)

T8.93 Joint or other Synovial Cavity, Aspiration of, or Injection into (Items 50124, 50125)

T8.93.1 Item 50124 is restricted to a maximum of 25 treatments in a 12 month period. Where additional treatments are necessary item 50125 applies. Claims for benefits should be accompanied by full clinical details to verify the need for additional services. Where digital photographs are supplied, the practitioner must sign each photograph to 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.)

T8.94 Non-resectable Hepatocellular Carcinoma Destruction of by Open or Laparoscopic Radiofrequency Ablation (50952)

T8.94.1 A multi-disciplinary team for the purposes of item 50952 would include a hepatobilliary surgeon, interventional radiologist and a gastroenterologist or oncologist.

SUMMARY OF CHANGES - DIAGNOSTIC IMAGING SERVICES TABLE

Diagnostic imaging services contained in the Medicare Benefits Schedule (MBS) are managed under agreements signed between the diagnostic imaging profession representative organisations, and the Commonwealth (as represented by the Department of Health and Ageing). Since 1 July 2003 when the Radiology, Cardiac Imaging, Obstetric and Gynaecological Ultrasound and Nuclear Medicine '2003-2008 Quality and Outlays Memoranda of Understanding (MoUs)' came into effect, the profession and the Department have been reviewing the diagnostic imaging services outlined in the MBS. The changes detailed below are an outcome of this ongoing process.

GROUP I1: ULTRASOUND

Subgroup 1 - General

New post-void residual items 55084 and 55085
When a post-void residual is the only service clinically indicated and/or rendered, it is inappropriate to report a pelvic, urinary or abdominal ultrasound, instead of or in addition to this service (55084 or 55085). Similarly, if a complete pelvic, urinary or abdominal ultrasound is billed, it is inappropriate to bill separately for a post-void residual determination, since payment of this has already been included in the payment for the complete scans.

The report must contain an entry denoting the post-void residual amount and/or bladder capacity as calculated/estimated from the ultrasound device. In addition, the medical record must contain documentation of the indication for the service and the number of times performed.

Subgroup 2 - Cardiac

Amended item descriptor (Item 55118 transoesophageal echocardiography)
The item descriptor for 55118 has been amended to reflect that with current machines pulsed wave Doppler is no longer essential in every case.

Transoesophageal echocardiography - new Item 55135 and consequential amendment to Item 55130
The Medical Services Advisory Committee (MSAC) reviewed intra-operative transoesophageal echocardiography and recommended that public funding for this procedure be supported on an interim basis and be restricted to assessment of cardiac valve competence following valve replacement or repair. Item 55135 has been developed for these indications in consultation with the Australian Society of Anaesthetists, the Australian Medical Association and the Cardiac Society of Australia and New Zealand. Indications other than those recommended by MSAC will continue to be funded under item 55130 at a fee of $170.00. Further research will be undertaken to assist MSAC in its future evaluation of the use of intra-operative transoesophageal echocardiography.

GROUP I2: COMPUTED TOMOGRAPHY

Virtual colonoscopy
Amendments have been made to the item descriptions for items 56501, 56507, 56541 and 56547 to clarify that these items are not eligible for Medicare benefits if performed for the purpose of performing a virtual colonoscopy (otherwise known as CT colonography and CT colography).

GROUP I3: DIAGNOSTIC RADIOLOGY

Subgroup 10: Radiographic examination of the breasts

Items 59300 and 59303
The descriptors for mammography items 59300 and 59303 have been amended to reflect the clinical indications for bilateral versus unilateral examination. The term 'mammography' replaces 'radiographic examination of breast' in the items'description.

GROUP I4: NUCLEAR MEDICINE IMAGING

The Note which appeared in the descriptor of item 61302 has been removed. Refer to Note DIN.1 in the November 2003 MBS.

Fee Increase
To bring Medicare expenditure for Nuclear Medicine imaging services in line with agreed funding levels specified in the Nuclear Medicine 2003-2008 Quality and Outlays Memorandum of Understanding, (MoU) the MoU Management Committee which includes representatives from the Australian and New Zealand Association of Physicians in Nuclear Medicine and the Department of Health and Ageing recommended a six percent (6%) increase to the Schedule fee for all items in this Group effective from 1 May 2004. The 6% increase to the Schedule fee takes effect from 1 May 2004.

GROUP I5 - MAGNETIC RESONANCE IMAGING

Following a decision by MSAC and endorsement by the Radiology Management Committee, two new MRI scanning items 63960 and 63963 have been introduced for staging of cervical cancer.

Items 63960 or 63963 MRI scan of pelvis and upper abdomen for staging of cervical cancer, refer to FIGO stages. These are standard classifications of carcinoma from the International Federation of Gynaecology and Obstetrics.

SUMMARY OF CHANGES - PATHOLOGY SERVICES TABLE
Rule 14 and 16
Changes to rules 14 and 16 have been made to enable publicly owned pathology laboratories that have Approved Pathology Authority (APA) status to claim a referred specimen Medicare rebate (item 73921) for tests that are referred by a separate APA.

Group P3 - Microbiology
Items relating to respiratory antigens have been restructured to increase their diagnostic value. The restructure relates to the creation of 2 items (69373 and 69374) and consequential descriptor amendment of 3 items (69363, 69372 and 69375).

The Schedule fees for the detection of microbial antigens and nucleic acids have been reviewed to provide consistency for similar technologies and remove any ambiguities. This has resulted in fee changes to items 69363, 69369, 69370, 69372 and 69375 and the creation of item 69376.

Item 69444 (detection of Hepatitis C viral RNA) has been amended to enable an RNA viral load test to be available for all hepatitis C sero-positive patients. The amendment removes the requirement for two normal liver function tests.

Group P4 - Immunology
A new item (71146) has been created to provide for CD34 assay. It is anticipated that this new item and the consequential change to item 71139 will reflect current clinical practice. It should be noted that any benefits paid in respect of item 71146 are not payable in testing with cord blood banking or embryonic stem cell testing.

Part 5 - Complexity Levels for Histopathology Items
An amendment to the complexity level for melanoma in situ has raised the complexity level from 3 to 5. This change acknowledges that melanoma in situ requires extra work to examine multiple levels to confirm the diagnosis and to exclude the possibility of an invasive component. The new complexity level is -

Skin, resection of malignant melanoma or melanoma in situ. 5

SUMMARY OF CHANGES

The 1 May 2004 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) new reference to note
*	(e) corrected item descriptions

New Items

710 11820 12201 32103 32104 32106 34538 34539 36526 36527 40905 50950
50952 55084 55085 55135 63960 63963 69373 69374 69376 71146

Deleted Items

11706

Amended Description

30096 30419 31200 31340 32024 32025 32159 32162 35321 35576 35580 35584
35590 35593 35599 35600 35602 35605 36564 37042 37043 37044 38436 55118
55130 56501 56507 56541 56547 61302 69363 69372 69375 69444 71139

Fee Amended

55130 61302 61303 61306 61307 61310 61313 61314 61316 61317 61320 61328
61340 61348 61352 61353 61356 61360 61361 61364 61368 61369 61372 61373
61376 61381 61383 61384 61386 61387 61389 61390 61393 61397 61401 61402
61405 61409 61413 61417 61421 61425 61426 61429 61430 61433 61434 61437
61438 61441 61442 61445 61446 61449 61450 61453 61454 61457 61458 61461
61462 61465 61469 61473 61480 61484 61485 61495 61499 69363 69369 69370
69372 69375

New References to Note T7.6

18234 18236 18238 18240 18242 18244 18246 18248 18250 18252 18254 18256
18258 18260 18262 18264 18266 18268 18270 18272 18274 18276 18278 18280
18282 18284 18286 18288

Corrected Item Descriptions for Items incorrectly printed in 1 November 2003 MBS

11221 11222 11224 11225 11235 11237 11240 11241 11242 11243

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 2004 and continues beyond that date, the old (1 November 2003) 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.

ENHANCED PRIMARY CARE	ENHANCED PRIMARY CARE
	GROUP A14 - HEALTH ASSESSMENTS
† 710	ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH CHECK Attendance by a medical practitioner, other than a specialist or a consultant physician, at consulting rooms or in another place other than a hospital or Residential Aged Care Facility, for an adult health check of a patient who is of Aboriginal or Torres Strait Islander descent and aged 15 to 54 years (inclusive) - not being an adult health check of a patient in respect of whom, in the preceding 18 months, a payment has been made under this item **Fee:** $187.70 **Benefit:** 75% = $140.80 85% = $159.55
DIAGNOSTIC	**OPHTHALMOLOGY**
	GROUP D1 - MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
	SUBGROUP 2 - OPHTHALMOLOGY
* 11221	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving 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 D1.6 and D1.8 of explanatory notes to this Category)* **Fee:** $56.30 **Benefit:** 75% = $42.25 85% = $47.90
* 11222	FULL QUANTITATIVE COMPUTERISED PERIMETRY (automated absolute static threshold) not being a service involving 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 one of the following conditions:-*** . established glaucoma (where surgery may be required within a six month period) 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 . monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be other disease such as glaucoma or neurological disease **- *each additional examination*** *(See para D1.6, D1.7 and D1.8 of explanatory notes to this Category)* **Fee:** $56.30 **Benefit:** 75% = $42.25 85% = $47.90
* 11224	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving 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 D1.6, and D1.8 of explanatory notes to this Category* **Fee:** $33.95 **Benefit:** 75% = $25.50 85% = $28.90
* 11225	FULL QUANTITATIVE COMPUTERISED PERIMETRY - (automated absolute static threshold) not being a service involving 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 may be required within a 6 month period) 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 . monitoring for ocular disease or disease of the visual pathways which may be caused by systemic drug toxicity, where there may also be other disease such as glaucoma or neurological disease **- *each additional examination*** *(See para D1.6, D1.7 and D1.8 of explanatory notes to this Category)* **Fee:** $33.95 **Benefit:** 75% = $25.50 85% = $28.90
* 11235	EXAMINATION OF THE EYE BY IMPRESSION CYTOLOGY OF CORNEA for the investigation of ocular surface dysplasia, including the collection of cells, processing and all cytological examinations and preparation of report **Fee:** $101.95 **Benefit:** 75% = $76.50 85% = $86.70
* 11237	OCULAR CONTENTS**,** simultaneous ultrasonic echography by both unidimensional and bidimensional techniques, for the diagnosis, monitoring or measurement of choroidal and ciliary body melanomas, retinoblastoma or suspicious naevi or simulating lesions, one eye, not being a service associated with a service to which items in Group I1 apply **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55

* 11240	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for the measurement of one eye prior to lens surgery on that eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.9 of explanatory notes to this Category)* **Fee:** $67.65 **Benefit:** 75% = $50.75 85% = $57.55
* 11241	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for bilateral eye measurement prior to lens surgery on both eyes, not being a service associated with a service to which items in Group I1 apply *(See para D1.9 of explanatory notes to this Category)* **Fee:** $86.15 **Benefit:** 75% = $64.65 85% = $73.25
* 11242	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for the measurement of an eye previously measured and on which lens surgery has been performed, and where further lens surgery is contemplated in that eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.9 of explanatory notes to this Category)* **Fee:** $66.60 **Benefit:** 75% = $49.95 85% = $56.65
* 11243	ORBITAL CONTENTS, ultrasonic echography of, unidimensional, for the measurement of a second eye where surgery for the first eye has resulted in more than 1 dioptre of error or where more than 3 years have elapsed since the surgery for the first eye, not being a service associated with a service to which items in Group I1 apply *(See para D1.9 of explanatory notes to this Category)* **Fee:** $66.60 **Benefit:** 75% = $49.95 85% = $56.65
	SUBGROUP 7 - GASTROENTEROLOGY & COLORECTAL
† 11820	CAPSULE ENDOSCOPY to investigate an episode of obscure gastrointestinal bleeding, using a capsule endoscopy device approved by the Therapeutic Goods Administration (including administration of the capsule, imaging, image reading and interpretation, and all attendances for providing the service on the day the capsule is administered) if: (a) the service is performed by a specialist or consultant physician with endoscopic training that is recognised by The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy; and (b) the patient to whom the service is provided: (i) is aged 18 years or over; and (ii) has recurrent or persistent bleeding; and (iii) is anaemic or has active bleeding; and (c) an upper gastrointestinal endoscopy and a colonoscopy have been performed on the patient and have not identified the cause of the bleeding; and (d) the service is performed within 6 months of the upper gastrointestinal endoscopy and colonoscopy *(See para D1.21 of explanatory notes to this Category)* **Fee:** $1,694.65 **Benefit:** 75% = $1,271.00 85% = $1,636.05
	SUBGROUP 10 - OTHER DIAGNOSTIC PROCEDURES AND INVESTIGATIONS
† 12201	Administration, by a specialist or consultant physician in the practice of his or her specialty, of thyrotropin alfa-rch (recombinant human thyroid-stimulating hormone), and arranging services to which both items 61426 and 66650 apply, for the detection of recurrent well-differentiated thyroid cancer in a patient who: (a) has had a total thyroidectomy and one ablative dose of radioactive iodine; and (b) is maintained on thyroid hormone therapy; and (c) is at risk of recurrence; and (d) on at least one previous whole body scan or serum thyroglobulin test when withdrawn from thyroid hormone therapy did not have evidence of well differentiated thyroid cancer; and (i) withdrawal from thyroid hormone therapy resulted in severe psychiatric disturbances when hypothyroid; or (ii) withdrawal is medically contraindicated because the patient has: - unstable coronary artery disease; or - hypopituitarism ; or - a high risk of relapse of exacerbation of a previous severe psychiatric illness payable once only in any twelve month period. *(See para D1.23 of explanatory notes to this Category)* **Fee:** $1,988.65 **Benefit:** 75% = $1,491.50 85% = $1,930.05

	GROUP T7 - REGIONAL OR FIELD NERVE BLOCKS
# 18234	TRIGEMINAL NERVE, primary division of, injection of an anaesthetic agent (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $103.75 **Benefit:** 75% = $77.85 85% = $88.20
# 18236	TRIGEMINAL NERVE, peripheral branch of, injection of an anaesthetic agent (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
# 18238	FACIAL NERVE, injection of an anaesthetic agent, not being a service associated with a service to which item 18240 applies *(See para T7.6 of explanatory notes to this Category)* **Fee:** $31.25 **Benefit:** 75% = $23.45 85% = $26.60
# 18240	RETROBULBAR OR PERIBULBAR INJECTION of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $77.75 **Benefit:** 75% = $58.35 85% = $66.10
# 18242	GREATER OCCIPITAL NERVE, injection of an anaesthetic agent (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $31.25 **Benefit:** 75% = $23.45 85% = $26.60
# 18244	VAGUS NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20
# 18246	GLOSSOPHARYNGEAL NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20
# 18248	PHRENIC NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $73.70 **Benefit:** 75% = $55.30 85% = $62.65
# 18250	SPINAL ACCESSORY NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
# 18252	CERVICAL PLEXUS, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20
# 18254	BRACHIAL PLEXUS, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20
# 18256	SUPRASCAPULAR NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
# 18258	INTERCOSTAL NERVE (single), injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
# 18260	INTERCOSTAL NERVES (multiple), injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $73.70 **Benefit:** 75% = $55.30 85% = $62.65
# 18262	ILIO-INGUINAL, ILIOHYPOGASTRIC OR GENITOFEMORAL NERVES, 1 or more of, injection of an anaesthetic agent (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95 **Benefit:** 75% = $39.00 85% = $44.20
# 18264	PUDENDAL NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $83.75 **Benefit:** 75% = $62.85 85% = $71.20

# 18266	ULNAR, RADIAL OR MEDIAN NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent, not being associated with a brachial plexus block *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95	**Benefit:** 75% = $39.00	85% = $44.20
# 18268	OBTURATOR NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $73.70	**Benefit:** 75% = $55.30	85% = $62.65
# 18270	FEMORAL NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $73.70	**Benefit:** 75% = $55.30	85% = $62.65
# 18272	SAPHENOUS, SURAL, POPLITEAL OR POSTERIOR TIBIAL NERVE, MAIN TRUNK OF, 1 or more of, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $51.95	**Benefit:** 75% = $39.00	85% = $44.20
# 18274	PARAVERTEBRAL, CERVICAL, THORACIC, LUMBAR, SACRAL OR COCCYGEAL NERVES, injection of an anaesthetic agent, (single vertebral level) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $73.70	**Benefit:** 75% = $55.30	85% = $62.65
# 18276	PARAVERTEBRAL NERVES, injection of an anaesthetic agent, (multiple levels) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $103.75	**Benefit:** 75% = $77.85	85% = $88.20
# 18278	SCIATIC NERVE, injection of an anaesthetic agent *(See para T7.6 of explanatory notes to this Category)* **Fee:** $73.70	**Benefit:** 75% = $55.30	85% = $62.65
# 18280	SPHENOPALATINE GANGLION, injection of an anaesthetic agent (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $103.75	**Benefit:** 75% = $77.85	85% = $88.20
# 18282	CAROTID SINUS, injection of an anaesthetic agent, as an independent percutaneous procedure *(See para T7.6 of explanatory notes to this Category)* **Fee:** $83.75	**Benefit:** 75% = $62.85	85% = $71.20
# 18284	STELLATE GANGLION, injection of an anaesthetic agent, (cervical sympathetic block) (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $122.70	**Benefit:** 75% = $92.05	85% = $104.30
# 18286	LUMBAR OR THORACIC NERVES, injection of an anaesthetic agent, (paravertebral sympathetic block) (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $122.70	**Benefit:** 75% = $92.05	85% = $104.30
# 18288	COELIAC PLEXUS OR SPLANCHNIC NERVES, injection of an anaesthetic agent (Anaes.) *(See para T7.6 of explanatory notes to this Category)* **Fee:** $122.70	**Benefit:** 75% = $92.05	85% = $104.30

	GROUP T8 - SURGICAL OPERATIONS
	SUBGROUP 1 - GENERAL
‡ 30096	DIAGNOSTIC SCALENE NODE BIOPSY, by open procedure, where the specimen excised is sent for pathological examination (Anaes.) *(See para T8.11 of explanatory notes to this Category)* **Fee:** $152.85 **Benefit:** 75% = $114.65 85% = $129.95
‡ 30419	LIVER TUMOURS, destruction of, by hepatic cryotherapy, not being a service associated with a service to which item 50950 or 50952 applies (Anaes.) (Assist.) **Fee:** $679.10 **Benefit:** 75% = $509.35 85% = $620.50
‡ 31200	TUMOUR (other than viral verrucae [common warts] and seborrheic keratoses), CYST, ULCER OR SCAR (other than a scar removed during the surgical approach to an operation), **removal by surgical excision (other than shave excision) and suture from cutaneous or subcutaneous tissue or from mucous membrane,** not being a service to which another item in this Group applies *(See para T8.21 of explanatory notes to this Category)* **Fee:** $28.25 **Benefit:** 75% = $21.20 85% = $24.05
‡ 31340	**NOTE:** *Multiple Operation and Multiple Anaesthetic rules apply to this item.* MUSCLE, BONE OR CARTILAGE, excision of one or more of, where clinically indicated, where the specimen excised is sent for histological confirmation, performed in association with excision of malignant tumour of skin covered by item **31255, 31260, 31265, 31270, 31275, 31280, 31285, 31290, 31295, 31300, 31305, 31310, 31315, 31320, 31325, 31330 or 31335** (Anaes.) *(See para T8.21 of explanatory notes to this Category)* **Derived Fee:** 75% of the fee for excision of malignant tumour
	SUBGROUP 2 - COLORECTAL
‡ 32024	RECTUM, HIGH RESTORATIVE ANTERIOR RESECTION WITH INTRAPERITONEAL ANASTOMOSIS (of the rectum) greater than 10 centimetres from the anal verge excluding resection of sigmoid colon alone not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,134.05 **Benefit:** 75% = $850.55 85% = $1,075.45
‡ 32025	RECTUM, LOW RESTORATIVE ANTERIOR RESECTION WITH EXTRAPERITONEAL ANASTOMOSIS (of the rectum) less than 10 centimetres from the anal verge, with or without covering stoma not being a service associated with a service to which item 32103, 32104 or 32106 applies (Anaes.) (Assist.) **Fee:** $1,516.90 **Benefit:** 75% = $1,137.70 85% = $1,458.30
† 32103	RECTAL TUMOUR, of less than 4cm in diameter, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy or by local excision not being a service associated with a service to which item 32024, 32025, 32104 or 32106 applies (Anaes.) (Assist.) *(See para T8.18 and T8.29 of explanatory notes to this Category)* **Fee:** $641.80 **Benefit:** 75% = $481.35 85% = $583.20
† 32104	RECTAL TUMOUR, of 4cm or greater in diameter, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy or by local excision not being a service associated with a service to which item 32024, 32025, 32103 or 32106 applies (Anaes.) (Assist.) *(See para T8.18 and T8.29 of explanatory notes to this Category)* **Fee:** $830.75 **Benefit:** 75% = $623.10 85% = $772.15
† 32106	ANTEROLATERAL INTRAPERITONEAL RECTAL TUMOUR, per anal excision of, using stereoscopic rectoscopy (incorporating stereoscopic and optic systems), where removal is unable to be performed during colonoscopy and where removal requires dissection within the peritoneal cavity not being a service associated with a service to which item 32024, 32025, 32103 or 32104 applies (Anaes.) (Assist.) *(See para T8.18 and T8.29 of explanatory notes to this Category)* **Fee:** $1,134.05 **Benefit:** 75% = $850.55 85% = $1,075.45
‡ 32159	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the lower half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $276.95 **Benefit:** 75% = $207.75 85% = $235.45

‡ 32162	ANAL FISTULA, treatment of, by excision or by insertion of a Seton, or by a combination of both procedures, involving the upper half of the anal sphincter mechanism (Anaes.) (Assist.) **Fee:** $402.20 **Benefit:** 75% = $301.65 85% = $343.60
	SUBGROUP 3 - VASCULAR
† 34538	CENTRAL VEIN CATHERTERISATION by percutaneous technique, using subcutaneous tunnelled cuffed catheter or similar device, for the administration of haemodialysis or parenteral nutrition (Anaes.) **Fee:** $226.35 **Benefit:** 75% = $169.80 85% = $192.40
† 34539	TUNNELLED CUFFED CATHETER, OR SIMILAR DEVICE, removal of, by open surgical procedure in the operating theatre of a hospital or approved day-hospital facility (Anaes.) **Fee:** $169.80 **Benefit:** 75% = $127.35 85% = $144.35
‡ 35321	PERIPHERAL ARTERIAL OR VENOUS CATHETERISATION to administer agents to occlude arteries, veins or arterio-venous fistulae or to arrest haemorrhage, (but not for the treatment of uterine fibroids) percutaneous or by open exposure, excluding associated radiological services or preparation, and excluding aftercare, not being a service associated with photodynamic therapy with verteporfin (Anaes.) (Assist.) *(See para T8.35 of explanatory notes to this Category)* **Fee:** $675.85 **Benefit:** 75% = $506.90 85% = $617.25
	SUBGROUP 4 - GYNAECOLOGICAL
‡ 35576	ANTERIOR VAGINAL REPAIR OR POSTERIOR VAGINAL REPAIR (involving repair of rectocele or enterocele or both) with or without mesh, not being a service associated with a service to which item 30405, 35580 or 35584 applies (Anaes.) (Assist.) **Fee:** $353.20 **Benefit:** 75% = $264.90 85% = $300.25
‡ 35580	ANTERIOR VAGINAL REPAIR AND POSTERIOR VAGINAL REPAIR (involving repair of rectocele or enterocele or both) with or without mesh, not being a service associated with a service to which item 30405 or 35584 applies (Anaes.) (Assist.) **Fee:** $445.45 **Benefit:** 75% = $334.10 85% = $386.85
‡ 35584	MANCHESTER (DONALDFOTHERGILL) OPERATION OR LE FORT OPERATION for genital prolapse, with or without mesh, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $560.55 **Benefit:** 75% = $420.45 85% = $501.95
‡ 35590	Operation involving ABDOMINAL APPROACH for repair of ENTEROCELE OR SUSPENSION OF VAGINAL VAULT OR ENTEROCELE AND SUSPENSION OF VAGINAL VAULT, with or without mesh, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $445.45 **Benefit:** 75% = $334.10 85% = $386.85
‡ 35593	VAGINAL REPAIR OF ENTEROCELE with or without repair of rectocele, with or without mesh, not being a service associated with a service to which item 30405, 35576, 35580, 35584, 35590, 35657, 35673, 35750 or 35753 applies, and where on a previous occasion there has been performed surgery reflected by a procedure to which item 35576, 35580, 35584, 35590, 35657, 35673, 35750 or 35753 applies (Anaes.) (Assist.) **Fee:** $445.45 **Benefit:** 75% = $334.10 85% = $386.85
‡ 35599	STRESS INCONTINENCE, sling operation for, with or without mesh, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $560.55 **Benefit:** 75% = $420.45 85% = $501.95
‡ 35600	STRESS INCONTINENCE, VAGINAL PROCEDURE FOR, with or without mesh, not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $435.15 **Benefit:** 75% = $326.40 85% = $376.55
‡ 35602	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; abdominal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Anaes.) (Assist.) **Fee:** $560.55 **Benefit:** 75% = $420.45 85% = $501.95
‡ 35605	STRESS INCONTINENCE, combined synchronous ABDOMINOVAGINAL operation for; vaginal procedure, with or without mesh, (including aftercare), not being a service associated with a service to which item 30405 applies (Assist.) **Fee:** $304.10 **Benefit:** 75% = $228.10 85% = $258.50

	SUBGROUP 5 - UROLOGICAL
† 36526	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour less than 10cms in diameter, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) *(See para T8.44 of explanatory notes to this Category)* **Fee:** $1,073.00 **Benefit:** 75% = $804.75 85% = $1,014.40
† 36527	NEPHRECTOMY, radical with en bloc dissection of lymph nodes, with or without adrenalectomy, for a tumour 10cms or more in diameter, or complicated by previous open or laparoscopic surgery on the same kidney, where performed if malignancy is clinically suspected but not confirmed by histopathological examination (Anaes.) (Assist.) *(See para T8.44 of explanatory notes to this Category)* **Fee:** $1,324.20 **Benefit:** 75% = $993.15 85% = $1,265.60
‡ 36564	PYELOPLASTY, (plastic reconstruction of the pelvi-ureteric junction) by open exposure, laparoscopy or laparoscopic assisted techniques (Anaes.) (Assist.) **Fee:** $768.40 **Benefit:** 75% = $576.30 85% = $709.80
‡‡ 37042	BLADDER STRESS INCONTINENCE, sling procedure for, using autologous fascial sling, including harvesting of sling, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $757.35 **Benefit:** 75% = $568.05 85% = $698.75
‡ 37043	BLADDER STRESS INCONTINENCE, Stamey or similar type needle colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $560.55 **Benefit:** 75% = $420.45 85% = $501.95
‡ 37044	BLADDER STRESS INCONTINENCE, suprapubic procedure for, eg Burch colposuspension, with or without mesh, not being a service associated with a service to which item 30405 or 35599 applies (Anaes.) (Assist.) **Fee:** $574.95 **Benefit:** 75% = $431.25 85% = $516.35
	SUBGROUP 6 - CARDIO-THORACIC
‡ 38436	THORACOSCOPY, with or without division of pleural adhesions, including insertion of intercostal catheter where necessary, with or without biopsy (Anaes.) **Fee:** $207.55 **Benefit:** 75% = $155.70 85% = $176.45
	SUBGROUP 7 - NEUROSURGICAL
† 40905	CRANIOTOMY, performed in association with items 45767, 45776, 45782 and 45785 for the correction of craniofacial abnormalities (Anaes.) **Fee:** $500.00 **Benefit:** 75% = $375.00 85% = $441.40
	SUBGROUP 16 - RADIOFREQUENCY ABLATION
† 50950	NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by percutaneous radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50952 applies (Anaes.) **Fee:** $679.10 **Benefit:** 75% = $509.35 85% = $620.50
† 50952	NONRESECTABLE HEPATOCELLULAR CARCINOMA, destruction of, by open or laparoscopic radiofrequency ablation, where a multi-disciplinary team has assessed that percutaneous radiofrequency ablation cannot be performed or is not practical because of one or more of the following clinical circumstances: - percutaneous access cannot be achieved; - vital organs/tissues are at risk of damage from the percutaneous RFA procedure; or - resection of one part of the liver is possible however there is at least one primary liver tumour in a non-resectable region of the liver which is suitable for radiofrequency ablation, including any associated imaging services, not being a service associated with a service to which item 30419 or 50950 applies (Anaes.) *(See para T8.94 of explanatory notes to this Category)* **Fee:** $679.10 **Benefit:** 75% = $509.35 85% = $620.50

	GROUP I1 - ULTRASOUND
	SUBGROUP 1 - GENERAL
† 55084	URINARY BLADDER, ultrasound scan of, by any or all approaches, where: (a) the patient is referred by a medical practitioner for ultrasonic examination not being a service associated with a service to which an item in Subgroups 2 or 3 of the Group applies; and (b) the referring medical practitioner is not a member of a group of practitioners of which the providing practitioner is a member; and (c) the service is not performed with item 55600, 55603, 55036, 55038, 55044, 55731 or 11917 on the same date of service (R) **Fee:** $90.00 **Benefit:** 75% = $67.50 85% = $76.50
† 55085	URINARY BLADDER, ultrasound scan of, by any or all approaches, where the patient is not referred by a medical practitioner, not being a service associated with a service to which an item in Subgroups 2 or 3 applies; and the service is not performed with item 55600, 55603, 55037, 55039, 55045, 55733 or 11917 on the same date of service (NR) **Fee:** $31.20 **Benefit:** 75% = $23.40 85% = $26.55
	SUBGROUP 2 - CARDIAC
‡ 55118	HEART, 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL EXAMINATION of, from at least two levels, and in more than one plane at each level: (a) with: (i) real time colour flow mapping and, if indicated, pulsed wave Doppler examination; and (ii) recordings on video tape or digital medium; and (b) not being an intra-operative service or a service associated with a service to which an item in Subgroups 1 (with the exception of item 55054) or 3, applies (R) (Anaes.) **Fee:** $275.50 **Benefit:** 75% = $206.65 85% = $234.20
‡ + 55130	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac surgery incorporating sequential assessment of cardiac function before and after the surgical procedure - not associated with item 55135 (R) (Anaes.) *(See para DIK. of explanatory notes to this Category)* **Fee:** $170.00 **Benefit:** 75% = $127.50 85% = $144.50
† 55135	INTRA-OPERATIVE 2 DIMENSIONAL REAL TIME TRANSOESOPHAGEAL ECHOCARDIOGRAPHY incorporating Doppler techniques with colour flow mapping and recording onto video tape or digital medium, performed during cardiac valve surgery (repair or replacement) incorporating sequential assessment of cardiac function and valve competence before and after the surgical procedure - not associated with item 55130 (R) (Anaes.) **Fee:** $353.60 **Benefit:** 75% = $265.20 85% = $300.60

GROUP I2 - COMPUTED TOMOGRAPHY

UPPER ABDOMEN AND PELVIS

‡ 56501	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56801 or 57001 applies (R) (K) (Anaes.) **Fee:** $365.75 **Benefit:** 75% = $274.35 85% = $310.90
‡ 56507	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56807 or 57007 applies (R) (K) (Anaes.) **Fee:** $456.00 **Benefit:** 75% = $342.00 85% = $397.40
‡ 56541	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis without intravenous contrast medium, not for the purposes of virtual colonoscopy, not being a service to which item 56841 or 57041 applies (R) (NK) (Anaes.) **Fee:** $183.45 **Benefit:** 75% = $137.60 85% = $155.95
‡ 56547	COMPUTED TOMOGRAPHY - scan of upper abdomen and pelvis with intravenous contrast medium, and with any scans of upper abdomen and pelvis prior to intravenous contrast injection, when undertaken, not for the purposes of virtual colonoscopy, not being a service to which item 56847 or 57047 applies (R) (NK) (Anaes.) **Fee:** $231.55 **Benefit:** 75% = $173.70 85% = $196.85

GROUP I4 - NUCLEAR MEDICINE IMAGING

‡ + 61302	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - planar imaging (R) **Fee:** $431.45 **Benefit:** 75% = $323.60 85% = $372.85
+ 61303	SINGLE STRESS OR REST MYOCARDIAL PERFUSION STUDY - with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $543.40 **Benefit:** 75% = $407.55 85% = $484.80
+ 61306	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - planar imaging (R) **Fee:** $682.20 **Benefit:** 75% = $511.65 85% = $623.60
+ 61307	COMBINED STRESS AND REST, stress and re-injection or rest and redistribution myocardial perfusion study, including delayed imaging or re-injection protocol on a subsequent occasion - with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $802.55 **Benefit:** 75% = $601.95 85% = $743.95
+ 61310	MYOCARDIAL INFARCT-AVID-STUDY, with planar imaging and single photon emission tomography, OR planar imaging or single photon emission tomography (R) **Fee:** $353.05 **Benefit:** 75% = $264.80 85% = $300.10
+ 61313	GATED CARDIAC BLOOD POOL STUDY, (equilibrium), with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) **Fee:** $291.60 **Benefit:** 75% = $218.70 85% = $247.90
+ 61314	GATED CARDIAC BLOOD POOL STUDY, and first pass blood flow or cardiac shunt study, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $403.75 **Benefit:** 75% = $302.85 85% = $345.15
+ 61316	GATED CARDIAC BLOOD POOL STUDY, with intervention, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $366.40 **Benefit:** 75% = $274.80 85% = $311.45
+ 61317	GATED CARDIAC BLOOD POOL STUDY, with intervention and first pass blood flow study or cardiac shunt study, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) **Fee:** $473.30 **Benefit:** 75% = $355.00 85% = $414.70
+ 61320	CARDIAC FIRST PASS BLOOD FLOW STUDY OR CARDIAC SHUNT STUDY, not being a service to which another item in this Group applies (R) **Fee:** $220.05 **Benefit:** 75% = $165.05 85% = $187.05

+ 61328	LUNG PERFUSION STUDY, with planar imaging and single photon emission tomography OR planar imaging, or single photon emission tomography (R) **Fee:** $218.85 **Benefit:** 75% = $164.15 85% = $186.05
+ 61340	LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography OR planar imaging or single photon emission tomography (R) **Fee:** $243.20 **Benefit:** 75% = $182.40 85% = $206.75
+ 61348	LUNG PERFUSION STUDY AND LUNG VENTILATION STUDY using aerosol, technegas or xenon gas, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $426.15 **Benefit:** 75% = $319.65 85% = $367.55
+ 61352	LIVER AND SPLEEN STUDY (colloid) - planar imaging (R) **Fee:** $249.30 **Benefit:** 75% = $187.00 85% = $211.95
+ 61353	LIVER AND SPLEEN STUDY (colloid), with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $371.60 **Benefit:** 75% = $278.70 85% = $315.90
+ 61356	RED BLOOD CELL SPLEEN OR LIVER STUDY, including single photon emission tomography when undertaken (R) **Fee:** $377.55 **Benefit:** 75% = $283.20 85% = $320.95
+ 61360	HEPATOBILIARY STUDY, including morphine administration or pre-treatment with cholecystokinin (CCK) when undertaken (R) **Fee:** $387.70 **Benefit:** 75% = $290.80 85% = $329.55
+ 61361	HEPATOBILIARY STUDY with formal quantification following baseline imaging, using an infusion of cholecystokinin (CCK) (R) **Fee:** $443.55 **Benefit:** 75% = $332.70 85% = $384.95
+ 61364	BOWEL HAEMORRHAGE STUDY (R) **Fee:** $477.70 **Benefit:** 75% = $358.30 85% = $419.10
+ 61368	MECKEL'S DIVERTICULUM STUDY (R) **Fee:** $214.45 **Benefit:** 75% = $160.85 85% = $182.30
+ 61369	INDIUM-LABELLED OCTREOTIDE STUDY - including single photon emission tomography when undertaken, where: (a) there is a suspected gastro-entero-pancreatic endocrine tumour, based on biochemical evidence, with negative or equivocal conventional imaging; or (b) a surgically amenable gastro-entero-pancreatic endocrine tumour has been identified based on conventional techniques, in order to exclude additional disease sites. (Ministerial Determination)(R) **Fee:** $1,937.65 **Benefit:** 75% = $1,453.25 85% = $1,879.05
+ 61372	SALIVARY STUDY (R) **Fee:** $214.45 **Benefit:** 75% = $160.85 85% = $182.30
+ 61373	GASTRO-OESOPHAGEAL REFLUX STUDY, including delayed imaging on a separate occasion when undertaken (R) **Fee:** $470.75 **Benefit:** 75% = $353.10 85% = $412.15
+ 61376	OESOPHAGEAL CLEARANCE STUDY (R) **Fee:** $137.80 **Benefit:** 75% = $103.35 85% = $117.15
+ 61381	GASTRIC EMPTYING STUDY, using single tracer (R) **Fee:** $552.10 **Benefit:** 75% = $414.10 85% = $493.50
+ 61383	COMBINED SOLID AND LIQUID GASTRIC EMPTYING STUDY using dual isotope technique or the same isotope on separate days (R) **Fee:** $600.75 **Benefit:** 75% = $450.60 85% = $542.15
+ 61384	RADIONUCLIDE COLONIC TRANSIT STUDY (R) **Fee:** $661.05 **Benefit:** 75% = $495.80 85% = $602.45
+ 61386	RENAL STUDY, including perfusion and renogram images and computer analysis OR cortical study with planar imaging (R) **Fee:** $319.60 **Benefit:** 75% = $239.70 85% = $271.70
+ 61387	RENAL CORTICAL STUDY, with single photon emission tomography and planar quantification (R) **Fee:** $414.10 **Benefit:** 75% = $310.60 85% = $355.50

+ 61389	SINGLE RENAL STUDY with pre-procedural administration of a diuretic or angiotensin converting enzyme (ACE) inhibitor (R) **Fee:** $356.20	**Benefit:** 75% = $267.15	85% = $302.80
+ 61390	RENAL STUDY with diuretic administration following a baseline study (R) **Fee:** $394.10	**Benefit:** 75% = $295.60	85% = $335.50
+ 61393	COMBINED EXAMINATION INVOLVING A RENAL STUDY following angiotensin converting enzyme (ACE) inhibitor provocation and a baseline study, in either order and related to a single referral episode (R) **Fee:** $582.05	**Benefit:** 75% = $436.55	85% = $523.45
+ 61397	CYSTOURETEROGRAM (R) **Fee:** $237.30	**Benefit:** 75% = $178.00	85% = $201.75
+ 61401	TESTICULAR STUDY (R) **Fee:** $156.00	**Benefit:** 75% = $117.00	85% = $132.60
+ 61402	CEREBRAL PERFUSION STUDY, with single photon emission tomography and with planar imaging when undertaken (R) **Fee:** $581.60	**Benefit:** 75% = $436.20	85% = $523.00
+ 61405	BRAIN STUDY WITH BLOOD BRAIN BARRIER AGENT, with planar imaging and single photon emission tomography, OR planar imaging, or single photon emission tomography (R) **Fee:** $332.55	**Benefit:** 75% = $249.45	85% = $282.70
+ 61409	CEREBRO-SPINAL FLUID TRANSPORT STUDY, with imaging on 2 or more separate occasions (R) **Fee:** $839.65	**Benefit:** 75% = $629.75	85% = $781.05
+ 61413	CEREBRO-SPINAL FLUID SHUNT PATENCY STUDY (R) **Fee:** $217.20	**Benefit:** 75% = $162.90	85% = $184.65
+ 61417	DYNAMIC BLOOD FLOW STUDY OR REGIONAL BLOOD VOLUME QUANTITATIVE STUDY, not being a service associated with a service to which another item in this Group applies (R) **Fee:** $114.20	**Benefit:** 75% = $85.65	85% = $97.10
+ 61421	BONE STUDY - whole body, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $461.20	**Benefit:** 75% = $345.90	85% = $402.60
+ 61425	BONE STUDY - whole body and single photon emission tomography, with, when undertaken, blood flow, blood pool and delayed imaging on a separate occasion (R) **Fee:** $577.45	**Benefit:** 75% = $433.10	85% = $518.85
+ 61426	WHOLE BODY STUDY using iodine (R) **Fee:** $533.30	**Benefit:** 75% = $400.00	85% = $474.70
+ 61429	WHOLE BODY STUDY using gallium (R) **Fee:** $521.95	**Benefit:** 75% = $391.50	85% = $463.35
+ 61430	WHOLE BODY STUDY using gallium, with single photon emission tomography (R) **Fee:** $633.90	**Benefit:** 75% = $475.45	85% = $575.30
+ 61433	WHOLE BODY STUDY using cells labelled with technetium (R) **Fee:** $477.70	**Benefit:** 75% = $358.30	85% = $419.10
+ 61434	WHOLE BODY STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $591.55	**Benefit:** 75% = $443.70	85% = $532.95
+ 61437	WHOLE BODY STUDY using thallium (R) **Fee:** $521.75	**Benefit:** 75% = $391.35	85% = $463.15
+ 61438	WHOLE BODY STUDY using thallium, with single photon emission tomography (R) **Fee:** $646.90	**Benefit:** 75% = $485.20	85% = $588.30
+ 61441	BONE MARROW STUDY - whole body using technetium labelled bone marrow agents (R) **Fee:** $470.75	**Benefit:** 75% = $353.10	85% = $412.15
+ 61442	WHOLE BODY STUDY, using gallium - with single photon emission tomography of 2 or more body regions acquired separately (R) **Fee:** $723.20	**Benefit:** 75% = $542.40	85% = $664.60

+ 61445	BONE MARROW STUDY - localised using technetium labelled agent (R) **Fee:** $275.70 **Benefit:** 75% = $206.80 85% = $234.35
+ 61446	LOCALISED BONE OR JOINT STUDY, including when undertaken, blood flow, blood pool and repeat imaging on a separate occasion (R) **Fee:** $320.65 **Benefit:** 75% = $240.50 85% = $272.60
+ 61449	LOCALISED BONE OR JOINT STUDY and single photon emission tomography, including when undertaken, blood flow, blood pool and imaging on a separate occasion (R) **Fee:** $438.55 **Benefit:** 75% = $328.95 85% = $379.95
+ 61450	LOCALISED STUDY using gallium (R) **Fee:** $382.15 **Benefit:** 75% = $286.65 85% = $324.85
+ 61453	LOCALISED STUDY using gallium, with single photon emission tomography (R) **Fee:** $494.75 **Benefit:** 75% = $371.10 85% = $436.15
+ 61454	LOCALISED STUDY using cells labelled with technetium (R) **Fee:** $334.60 **Benefit:** 75% = $250.95 85% = $284.45
+ 61457	LOCALISED STUDY using cells labelled with technetium, with single photon emission tomography (R) **Fee:** $452.25 **Benefit:** 75% = $339.20 85% = $393.65
+ 61458	LOCALISED STUDY using thallium (R) **Fee:** $381.55 **Benefit:** 75% = $286.20 85% = $324.35
+ 61461	LOCALISED STUDY using thallium, with single photon emission tomography (R) **Fee:** $507.40 **Benefit:** 75% = $380.55 85% = $448.80
+ 61462	REPEAT PLANAR AND SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING, OR REPEAT PLANAR IMAGING OR SINGLE PHOTON EMISSION TOMOGRAPHY IMAGING on an occasion subsequent to the performance of any one of items 61364, 61426, 61429, 61430, 61442, 61450, 61453 or 61469, where there is no additional administration of radiopharmaceutical and where the previous radionuclide scan was abnormal or equivocal. (R) **Derived Fee:** The fee for the nuclear medicine investigation plus an amount of $125.25
+ 61465	VENOGRAPHY (R) **Fee:** $255.20 **Benefit:** 75% = $191.40 85% = $216.95
+ 61469	LYMPHOSCINTIGRAPHY (R) **Fee:** $334.60 **Benefit:** 75% = $250.95 85% = $284.45
+ 61473	THYROID STUDY including uptake measurement when undertaken (R) **Fee:** $168.60 **Benefit:** 75% = $126.45 85% = $143.35
+ 61480	PARATHYROID STUDY, planar imaging and single photon emission tomography when undertaken (R) **Fee:** $371.85 **Benefit:** 75% = $278.90 85% = $316.10
+ 61484	ADRENAL STUDY, with imaging on 2 or more separate occasions (R) **Fee:** $846.75 **Benefit:** 75% = $635.10 85% = $788.15
+ 61485	ADRENAL STUDY, with imaging on 2 or more occasions and renal localisation and single photon emission tomography when undertaken (R) **Fee:** $960.50 **Benefit:** 75% = $720.40 85% = $901.90
+ 61495	TEAR DUCT STUDY (R) **Fee:** $214.45 **Benefit:** 75% = $160.85 85% = $182.30
+ 61499	PARTICLE PERFUSION STUDY (intra-arterial) or Le Veen shunt study (R) **Fee:** $243.20 **Benefit:** 75% = $182.40 85% = $206.75

GROUP I5 - MAGNETIC RESONANCE IMAGING

SUBGROUP 31 - SCAN OF PELVIS AND UPPER AMDOMEN FOR THE FURTHER INVESTIGATION OF SPECIFIED CONDITIONS

Note: Benefits are payable for each service included by Subgroup 31 on one occasion only.

Magnetic Resonance Imaging, performed under the professional supervision of an eligible provider at an eligible location where:
(a) the patient is referred by a specialist or by a consultant physician; and
(b) the request for scan identifies that (i) a histological diagnosis of carcinoma of the cervix has been made and (ii) the patient has been diagnosed with cervical cancer at FIGO stage 1B or greater.

Scan for the further investigation of:

† 63960	- Pelvis for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Anaes.)		
	Fee: $475.00	**Benefit:** 75% = $356.25	85% = $416.40
† 63963	- Pelvis and upper amdomen, in a single examination, for the staging of histologically diagnosed cervical cancer at FIGO stages 1B or greater (R) (Anaes.)		
	Fee: $475.00	**Benefit:** 75% = $356.25	85% = $416.40

GROUP P3 - MICROBIOLOGY

‡ + 69363	Detection of *Clostridium difficile* or *Clostridium difficile* toxin (except if a service described in items 69345, 69369, 69370, 69372, 69373 or 69375 has been performed) - 1 or more tests		
	Fee: $28.85	**Benefit:** 75% = $21.65	85% = $24.55
+ 69369	Detection of chlamydia by any method in specimens from 1 or more sites		
	Fee: $28.85	**Benefit:** 75% = $21.65	85% = $24.55
+ 69370	Detection of chlamydia by any method and *Neisseria gonorrhoeae* by nucleic acid amplification techniques in specimens from 1 or more sites		
	Fee: $36.10	**Benefit:** 75% = $27.10	85% = $30.70
‡ + 69372	Detection of microbial antigens or nucleic acids (not elsewhere described in this table) - 1 or more tests		
	Fee: $28.85	**Benefit:** 75% = $21.65	85% = $24.55
† 69373	Detection of a virus or microbial antigen or nucleic acid from a respiratory tract specimen - 1 test		
	Fee: $28.85	**Benefit:** 75% = $21.65	85% = $24.55
† 69374	2 or more tests described in 69373		
	Fee: $36.10	**Benefit:** 75% = $27.10	85% = $30.70
‡ + 69375	Examination for Herpes simplex virus, varicella zoster virus or cytomegalovirus by culture or by detection of microbial antigen or nucleic acid, including a service described in item 69363, 69369, 69370, 69372 or 69373 (if performed) - 1 test		
	Fee: $28.85	**Benefit:** 75% = $21.65	85% = $24.55
† 69376	2 or more tests described in 69375		
	Fee: $36.10	**Benefit:** 75% = $27.10	85% = $30.70

‡ 69444	Detection of Hepatitis C viral RNA if at least 1 of the following criteria is satisfied: (a) the patient is Hepatitis C seropositive; (b) the patient's serological status is uncertain after testing; (c) the test is performed for the purpose of: (i) determining the Hepatitis C status of an immunosuppressed or immunocompromised patient; or (ii) the detection of acute Hepatitis C prior to seroconversion where considered necessary for the clinical management of the patient; Not exceeding 1 episode in a 12 month period (Item is subject to rule 19) **Fee:** $92.80 **Benefit:** 75% = $69.60 85% = $78.90
	GROUP P4 - IMMUNOLOGY
‡ 71139	Characterisation of 3 or more leucocyte surface antigens by immunofluorescence or immunoenzyme techniques to assess lymphoid or myeloid cell populations, including a total lymphocyte count or total leucocyte count by any method, on 1 or more specimens of blood, CSF or serous fluid **Fee:** $105.85 **Benefit:** 75% = $79.40 85% = $90.00
† 71146	Enumeration of CD34+ cells, only for the purposes of autologous or directed allogeneic haemopoietic stem cell transplantation, including a total white cell count **Fee:** $105.85 **Benefit:** 75% = $79.40 85% = $90.00
	GROUP P11 - SPECIMEN REFERRED
73921	Receipt of a specimen by an approved pathology practitioner of an approved pathology authority from another approved pathology practitioner of a different approved pathology authority or another approved pathology authority (Item is subject to rules 14, 15 and 16) **Fee:** $10.30 **Benefit:** 75% = $7.75 85% = $8.80